DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Immunization Program

Immunization Reporting Record

All Sections Required

Practice Name(1)**:**

Ordering Provider(2)**:** | **Administering Provider**(3)**:**

Patient Information

Patient's Name (Last, First)(4): | **Sex** (6): □Male □Female

Patient's Address(5): | **DOB** (7): / /

Ethnicity (8): □Hispanic □Non-Hispanic

City, State Zip Code:

RACE(9)**:** ☐**Caucasian** ☐**African American** ☐**Asian/Pacific Islander** ☐**Am. Indian/Alaskan Native** ☐**Other (Specify):**

Date of Immunization(10)	Funding Program	Funding Source(15)
IMPORTANT _____/_____/_____	☐ **VFC Eligible**(11)**:** ☐ Insurance Without Immunization Coverage ☐ Medicaid: (Pick One) ☐ Primary ☐ Secondary ☐ Medicaid Managed Care (Specify):_____ ☐ American Indian/Alaskan Native ☐ Uninsured ☐**Delaware Healthy Children Program**(12) ☐**Not VFC Eligible/Privately Insured**(13) ☐**317 Funded** □ Uninsured □ Underinsured (14)	Federal : □ VFC □ 317 State:□ CHIP □ Special Projects Private: □ Private Stock **Adult HPV Program Provider** □ Uninsured □ Underinsured

Immunization(s) Administered(16)

Vaccine	Manufacturer/Type	VIS Pub. Date	Dose	Route	Site	Lot #	Exp. Date
DT	☐ Sanofi						
DTaP	☐ Sanofi ☐ GSK						
DTaP/HepB/IPV (Pediarix)	☐ GSK						
DTaP/IPV (Kinrix)	☐ GSK						
DTaP/Hib/IPV (Pentacel)	☐ Sanofi						
Td	☐ Sanofi ☐ Merck						
Tdap	☐ Sanofi ☐ GSK						
Hep A	☐ Merck ☐ GSK						
Hep A/B	☐ GSK						
Hep B	☐ Merck ☐ GSK						
Hep B (2 dose)	☐ Merck						
HepB/Hib (Comvax)	☐ Merck						
Hib	☐ Sanofi ☐ Merck						
HPV	☐ Merck ☐ GSK						
Influenza							
IPV	☐ Sanofi						
MCV4 (Menactra/Menveo)	☐ Sanofi ☐ Novartis						
☐**MMR or** ☐**MMR/V** (Proquad)	☐ Merck						
Prevnar 13 (PCV 13)	☐ Pfizer						
Pneu. Poly (23)	☐ Merck						
Rabies	☐ Sanofi ☐ Novartis						
Rotavirus	☐ Merck ☐ GSK						
Zoster (Shingles)	☐ Merck						
Varicella	☐ Merck						
Other:	☐						

(Revised: 09/13/2018)

Immunization Reporting Record Instructions

1) Practice Name: Print the name of the practice reporting the immunization.
2) Administering Provider Name: Print the name of the Provider (MD/NP)responsible for the administration of vaccine
3) Patient Name: Print the name of the patient.
4) Patient Address: Print the address of the patient.
5) Sex: Check the appropriate box.
6) Date of Birth: Enter the patient's date of birth.
7) Ethnicity: Check the appropriate box.
8) Race: Check the appropriate box.
9) Date of Immunization: Enter the date the immunization(s) to be reported was administered.
10) VFC-eligible: Check for VFC eligible clients and indicate the eligibility criteria.
    a. Patients in the category of *"Insurance without Immunization Coverage"* must be referred to a Federally Qualified Health Center (FQHC) in order to receive VFC vaccine. Below is a list of FQHCs in Delaware:

Henrietta Johnson Medical Center	**Westside Health Center** (302) 224-6800
Eastside Location (302) 655-6187	1802 West 4th Street
600 North Lombard Street	Wilmington, DE 19805
Wilmington, DE 19801	
Henrietta Johnson Medical Center	**Westside Health Center** (302) 678-4622
Southbridge Location (302) 655-6187	Gateway West
601 New Castle Avenue	1020 Forrest Ave. Suite 1
Wilmington, DE 19801	Dover, DE 19904
La Red Health Center (302) 855-1233	
505-A West Market Street	
Georgetown, DE 19947	

11) Delaware Healthy Children Program (DHCP): Check only if patient has insurance coverage with DHCP.
12) Not VFC Eligible/Privately Insured: Check if patient is age 19 and over or patient has private insurance.
13) 317 Funded: Check if using Section 317 funded vaccine and insurance status for non VFC-eligible patients. Please call the Immunization Program with questions at 1-800-282-8672.
14) Funding Source: Check the appropriate source of how the vaccine was funded. For the Adult HPV Program, check if patient was vaccinated using vaccine from the Adult HPV Vaccine Program and check the appropriate eligibility status.
15) Immunization(s) Administered: Check all immunizations administered to the patient on the date documented in #9 and must include all areas. For Influenza Vaccine, include type (i.e. Quadrivalent or Trivalent). Below are definitions of route and site codes that are needed for submission.

Site Codes		Route Codes
Code & Definition	Code & Definition	Code & Definition
IN-Intranasal	PO-Oral	ID-Intradermal
LALT-Left Anterior Lateral Thigh	RALT-Right Anterior Lateral Thigh	IM-Intramuscular
LFA-Left Arm	RFA-Right Arm	IT-Intravenous
LD-Left Deltoid	RD-Right Deltoid	NS-Nasal
LLFA-Left Lower Forearm	RLFA-Right Lower Forearm	PO-Oral
LPUA-Left Outer Aspect Upper Arm	RPUA-Right Outer Aspect Upper Arm	SC-Subcutaneous
LG-Left Upper Outer Quadrant Gluteus	RG-Right Upper Outer Quadrant Gluteus	
LVL-Left Vastus Lateralis	RVL-Right Vastus Lateralis	

Immunization History

Vaccine	Date	Date	Date	Date	Date

Return Completed Form To: Delaware Division of Public Health
Immunization Program
540 S. DuPont Hwy., Suite 4
Dover, DE 19901

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(Revised: 09/13/2018)