Arizona VFC Patient Immunization Log

Practice/Provider Name:

Address:

PIN:

Area Code & Phone number:

Area Code & Fax number:

VFC Contact:

Date log begins:

Date log ends:

VFC CODES*

NAME (optional)	DOB	Age	0	1	2	3	4	5	Dtap IPV Hib - Pentacel	Dtap IPV - Kinrix	Dtap	Dtap HepB Ipv - Pediarix	Hib	Hep B Hib	PCV 7	Rotavirus	IPV	Hep B	Hep A	MMR	VZV	MMRV	Td >7 yrs	PPV 23	HPV	Tdap	MCV4	Hep B 2 dose CHD only	Sanofi 0.25 ml single dose syringe 6-35m	Sanofi 0.5 ml single dose vial 3-18yrs	Sanofi 0.5 ml single dose syringe 3-18yrs	Sanofi 5.0 ml multi dose vial 3-18yrs	Novartis 0.5 mL 4-18yrs syring	MedImmune Flumist 5-18yrs
																									Adolescents				Influenza					
1																																		
2																																		
3																																		
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*VFC CODES= 0-KidsCare, 1-AHCCCS, 2-Uninsured, 3-Native American/Alaskan Native, 4-Underinsured, 5 Private Insurance

DO NOT FAX OR MAIL TO VFC. KEEP FOR YOUR RECORDS ONLY