

Otter Tail County Department of Public Health

Information About Person To Receive Vaccine

Name Last	Name First	Birthdate	Sex	Family Physician/Clinic
Address		Zip	County	Address
City		Home Phone		Work Phone
Parent/Guardian		Insurance Name and Numbers		

"I have been given a copy and have read or have had explained to me the information contained in the appropriate 'Vaccine Information Pamphlet(s)' (VIP) or 'Important Information Statement(s)' (IIS) about the disease(s) and vaccine(s) indicated. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the indicated vaccines and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request."

I understand the information contained within this record for the person named above is being maintained to monitor immunization needs in order to prevent disease. I realize that if I do not provide the personal information requested, immunization services may be denied. I understand that this information is private and will not be shared with anyone except the Minnesota Department of Health, licensed health care professionals such as doctors and nurses, schools, child care facilities, county public health agencies, community action agencies, or licensed health care facilities such as hospitals in order to assess and/or provide immunization services or to facilitate my child's future enrollment in a child care facility, school, or college.

Signature of person to receive vaccine or person authorized to make the request. _____

Date _____

Vaccine Type	Date of Imm	Site of Imm	Mfr & Lot #	Age at Imm	Route	Signature/Date of Person to receive vaccine or person authorized to make request	DATE _____		Signature/Title of Person Administering Vaccine
							ELIGIBILITY _____	ELIGIBILITY _____	
DTaP- Td									
POLIO									
HIB									
MMR									
HepB									
Varicella									

ALRT=Anterolateral Right Thigh
ALLT=Anterolateral Left Thigh

RD=Right Deltoid LD=Left Deltoid
* = Immunizations received elsewhere

OARUA=Outer Aspect of Right Upper Arm
OALUA=Outer Aspect of Left Upper Arm

IM=Intramuscular
SQ=Subcutaneous