Immunization Registry

Information About Person to Receive Vaccine *(please print)*

Patient's Medicaid Number:			Patient Social Security Number:		
Patient's Name: *Last* *First* *MI*		Birthdate	Sex	Race	Phone #
Parent's Name: *Last* *First* *MI*		Mother's Social Security Number:			
Address: *Street*					
City	*County*	*State*	*Zip*		

Initial/Date once vaccinations have been entered into MIIX.

_____
Initial

_____
Date

For Clinic/Office Use Only

Eligibility Status — VFC: ☐ Uninsured ☐ Medicaid ☐ American Indian ☐ Underinsured *(Insurance does not cover Immunizations)*
Insured: ☐ CHIP ☐ Private Insurance *(Insurance covers Immunizations)* ☐ Special Projects _____

VFC Pin#: _____ Facility Name: _____ Date Vaccinated & VIS issued: ____/____/____

Pentacel ☐ DTaP ☐ DTap/IPV/Hib | **Kinrix** ☐ DTap/IPV | **Pediarix** ☐ DTap/IPV/HepB
Manufacturer and Lot Number
Injection Site ☐ Right ☐ Left ☐ Arm ☐ Thigh *Route:* _____
VIS Revision Date _____/_____/_____

IPV
Manufacturer and Lot Number
Injection Site ☐ Right ☐ Left ☐ Arm ☐ Thigh *Route:* _____
VIS Revision Date _____/_____/_____

MMR
Manufacturer and Lot Number
Injection Site ☐ Right ☐ Left ☐ Arm ☐ Thigh *Route:* _____
VIS Revision Date _____/_____/_____

PedvaxHIB ☐ Hib (PRP-OMP) | **ActHIB** ☐ Hib (PRP-T) | **Hiberix** ☐ Hib (PRP-T)
Manufacturer and Lot Number
Injection Site ☐ Right ☐ Left ☐ Arm ☐ Thigh *Route:* _____
VIS Revision Date _____/_____/_____

Comvax ❑ Hep B ❑ Hep B/Hib
Manufacturer and Lot Number
Injection Site ☐ Right ☐ Left ☐ Arm ☐ Thigh *Route:* _____
VIS Revision Date _____/_____/_____

☐ **Varicella** ☐ **ProQuad MMRV**
Manufacturer and Lot Number
Injection Site ☐ Right ☐ Left ☐ Arm ☐ Thigh *Route:* _____
VIS Revision Date _____/_____/_____

Prevnar (PCV13)
Manufacturer and Lot Number
Injection Site ☐ Right ☐ Left ☐ Arm ☐ Thigh *Route:* _____
VIS Revision Date _____/_____/_____

Hep A
Manufacturer and Lot Number
Injection Site ☐ Right ☐ Left ☐ Arm ☐ Thigh *Route:* _____
VIS Revision Date _____/_____/_____

☐ **RotaTeq RV5** ☐ **Rotarix RV1**
Manufacturer and Lot Number
☐ *Oral*
VIS Revision Date _____/_____/_____

☐ **Gardasil HPV4** ☐ **Gardasil 9 HPV9** ☐ **Cervarix HPV2**
Manufacturer and Lot Number
Injection Site ☐ Right ☐ Left ☐ Arm ☐ Thigh *Route:* _____
VIS Revision Date _____/_____/_____

☐ **Menactra MCV4P** ☐ **Menveo MCV40** ☐ **Menomune MPSV4**
Manufacturer and Lot Number
Injection Site ☐ Right ☐ Left ☐ Arm ☐ Thigh *Route:* _____
VIS Revision Date _____/_____/_____

PPSV23
Manufacturer and Lot Number
Injection Site ☐ Right ☐ Left ☐ Arm ☐ Thigh *Route:* _____
VIS Revision Date _____/_____/_____

☐ **Td** ☐ **Tdap**
Manufacturer and Lot Number
Injection Site ☐ Right ☐ Left ☐ Arm ☐ Thigh *Route:* _____
VIS Revision Date _____/_____/_____

Other
Manufacturer and Lot Number
Injection Site ☐ Right ☐ Left ☐ Arm ☐ Thigh *Route:* _____
VIS Revision Date _____/_____/_____

Other
Manufacturer and Lot Number
Injection Site ☐ Right ☐ Left ☐ Arm ☐ Thigh *Route:* _____
VIS Revision Date _____/_____/_____

Prior to administration of the vaccine(s) checked above, a copy of the Vaccine Information Statement for each vaccine was provided to the client or representative of the child to whom the vaccine was administered. The clinic or his/her representative was given the opportunity to ask questions regarding the vaccine.

_____/Time: _____
Signature of Vaccine Administrator/Title

Prior to administration of the vaccine(s) checked above, a copy of the Vaccine Information Statement for each vaccine was provided to me. I was given the opportunity to ask questions regarding the vaccine(s) and agree to its administration.

_____
Signature of Vaccine Recipient or His/Her Parent or Representative

IMMUNIZATION REGISTRY
(Form 103)

PURPOSE

To document that vaccine administration immunization data has been entered into the Mississippi Immunization Information eXchange system (MIIX) and to record the identification data of a client receiving any vaccines listed on the form, the data about the vaccine administered, the health care provider information and the vaccine history of the client (if available).

INSTRUCTIONS

The *Immunization Registry* form must be completed if it is the provider's initial report for a client. After the initial visit, providers must continue to utilize this form to report immunization data to the statewide Registry. All immunizations administered at the same visit should be recorded on one *Immunization Registry* form.

The section of the form requiring information about the person receiving the vaccine must also be completed. Spaces provided for birth date, sex and race must be completed. (Male=M; Female=F; Black=B; White=W; Asian=A; Indian=I; other=Pacific Islanders, Alaskan Native, Hispanic, Non-Hispanic). Enter the client's Social Security Number and Medicaid Number if available. The parent's name and address are entered in the area shown. Enter the mother's Social Security Number in the space indicated. If appropriate, utilize the space provided for the address-o-graph at the top right-hand comer of the form. The VFC Pin # and facility name should be entered in the space indicated (a pin # will be assigned by the Immunization Program). The date vaccinated and vaccine information statement issued is to be entered in the space indicated. If the client is 18 years of age or younger, a check is placed in the corresponding box to indicate the Vaccines for Children (VFC) status. Please specify if a client participates in the Children Health Insurance Program (CHIP).

The vaccine administrator must check the appropriate box to show the vaccine administered on a particular visit. The manufacturer's name and lot number, the site of an injection, the route (intramuscular = IM, subcutaneous = SQ), vaccine information statement and revision date are to be recorded in the spaces indicated.

A section is provided to record clients' immunization history (if available). The vaccine administrator must write the dates of vaccines previously administered to the client. The date must include the month, day and year of administration. Also, a check should be placed in the box provided if the vaccine history has been previously submitted. It is not necessary to report history at each client's visit.

The signature and title of a vaccine administrator, and time must be entered to indicate a Vaccine Information Statement (VIS) was issued to a client or legal representative. Also, the vaccine recipient, parent, or representative signs in the space provided to verify that the Vaccine Information Statement was issued.

A telephone inquiry to the Immunization Registry can be made by calling 1-800-634-9251.

The initials and date are to be entered once the vaccine information has been entered into MIIX.

OFFICE MECHANICS AND FILING

The vaccine administrator should retain the white copy of Form 103 for office files.

RENTION PERIOD

According to the federal guidelines, the original copy of the Immunization Registry Form 103 must be retained for minors under 21 years of age until the 28th birthday. For adults 21 years of age or older, the Form 103 must be retained for a period of 10 years after the last service.