

**Please review the instructions and examples below.
Then complete the “Shot Grid” on the next page.**

Refer to your vaccination records for the child named on the labels on the front cover and next page of this form.

- ▶ Be sure to mark the box for the correct combination vaccine for each dose as shown in the example below. If the combination included both DTaP and Hib, or HepB and Hib, be sure to enter the information in both vaccine categories. Note that the same vaccine (a combination DTaP-Hib vaccine) is entered under both DTaP and Hib in the example below.

EXAMPLE												
Vaccine	Date Given			Given by other practice?		Type of Vaccine						
<i>Mark one box for each vaccine dose</i>												
DTaP	1	11	20	2010	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> DTaP/DTP	<input type="checkbox"/> DTaP-Hib	<input type="checkbox"/> DTaP-HepB-IPV ^a	<input type="checkbox"/> DTaP-IPV-Hib ^b			
	2	11	18	2011	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> DTaP/DTP	<input type="checkbox"/> DTaP-Hib	<input type="checkbox"/> DTaP-HepB-IPV ^a	<input checked="" type="checkbox"/> DTaP-IPV-Hib ^b			
<small>^aPediarix ^bPentacel</small>												
<i>Mark one box for each vaccine dose</i>												
Hib	1	11	20	2010	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Merck ^a	<input type="checkbox"/> sanofi ^b	<input type="checkbox"/> GSK ^c	<input type="checkbox"/> HepB-Hib	<input type="checkbox"/> DTaP-Hib	<input type="checkbox"/> DTaP-IPV-Hib ^d	<input type="checkbox"/> HibMenCY
	2	11	18	2011	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Merck ^a	<input type="checkbox"/> sanofi ^b	<input type="checkbox"/> GSK ^c	<input type="checkbox"/> HepB-Hib	<input type="checkbox"/> DTaP-Hib	<input type="checkbox"/> DTaP-IPV-Hib ^d	<input type="checkbox"/> HibMenCY
<small>^aPedvaxHIB[®], PRP-OMP ^bActHIB[®], PRP-T ^cHiberix[®], booster, PRP-T ^dPentacel</small>												

- ▶ Be sure to mark the “Yes” or “No” box under “Given by other practice?” for each vaccination (see example above).
- ▶ Be sure to mark the “Yes” or “No” box indicating “Given at birth?” for the first Hep B dose (see example below).

Hepatitis B	Month	Day	Year	Mark one box for each vaccine dose			
1	7	19	2010	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> HepB Only	<input type="checkbox"/> HepB-Hib	<input type="checkbox"/> DTaP-HepB-IPV ^a
<i>Dose 1 given at birth?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No							
2				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> HepB Only	<input type="checkbox"/> HepB-Hib	<input type="checkbox"/> DTaP-HepB-IPV ^a
<small>^aPediarix</small>							

- ▶ Use the “Other” space to enter any vaccines not listed on the next page or any additional doses of listed vaccines that were given to this child (see example below).

Other	Month	Day	Year	Mark one box for each vaccine dose		
1	11	20	2011	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

- ▶ After completing the “Shot Grid” on the next page, please return this form in the envelope provided. (Optional) You may also attach a copy of your immunization history records for this child to this form and send it back to

NORC at the University of Chicago,
National Immunization Survey
55 East Monroe Street, 19th Floor
Chicago IL 60603

If you choose this option, please answer all questions on page 1.

Or you may fax the confidential information to (866) 324-8659. If faxing this form, cut along fold to separate pages, then fax pages 1 and 3. Do not fax this page.

Vaccine	Date Given			Given by other practice?	Type of Vaccine						
	Month	Day	Year		Mark one box for each vaccine dose						
Hepatitis B	1			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> HepB Only	<input type="checkbox"/> HepB-Hib	<input type="checkbox"/> DTaP-HepB-IPV ^a				
	Dose 1 given at birth? <input type="checkbox"/> Yes <input type="checkbox"/> No										
	2			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> HepB Only	<input type="checkbox"/> HepB-Hib	<input type="checkbox"/> DTaP-HepB-IPV ^a				
	3			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> HepB Only	<input type="checkbox"/> HepB-Hib	<input type="checkbox"/> DTaP-HepB-IPV ^a				
	4			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> HepB Only	<input type="checkbox"/> HepB-Hib	<input type="checkbox"/> DTaP-HepB-IPV ^a				
^a Pediarix											
DTaP	1			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> DTaP/DTP	<input type="checkbox"/> DTaP-Hib	<input type="checkbox"/> DTaP-HepB-IPV ^a	<input type="checkbox"/> DTaP-IPV-Hib ^b			
	2			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> DTaP/DTP	<input type="checkbox"/> DTaP-Hib	<input type="checkbox"/> DTaP-HepB-IPV ^a	<input type="checkbox"/> DTaP-IPV-Hib ^b			
	3			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> DTaP/DTP	<input type="checkbox"/> DTaP-Hib	<input type="checkbox"/> DTaP-HepB-IPV ^a	<input type="checkbox"/> DTaP-IPV-Hib ^b			
	4			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> DTaP/DTP	<input type="checkbox"/> DTaP-Hib	<input type="checkbox"/> DTaP-HepB-IPV ^a	<input type="checkbox"/> DTaP-IPV-Hib ^b			
	5			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> DTaP/DTP	<input type="checkbox"/> DTaP-Hib	<input type="checkbox"/> DTaP-HepB-IPV ^a	<input type="checkbox"/> DTaP-IPV-Hib ^b			
^a Pediarix ^b Pentacel											
Hib	1			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Merck ^a	<input type="checkbox"/> sanofi ^b	<input type="checkbox"/> GSK ^c	<input type="checkbox"/> HepB-Hib	<input type="checkbox"/> DTaP-Hib	<input type="checkbox"/> DTaP-IPV-Hib ^d	<input type="checkbox"/> HibMenCY
	2			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Merck ^a	<input type="checkbox"/> sanofi ^b	<input type="checkbox"/> GSK ^c	<input type="checkbox"/> HepB-Hib	<input type="checkbox"/> DTaP-Hib	<input type="checkbox"/> DTaP-IPV-Hib ^d	<input type="checkbox"/> HibMenCY
	3			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Merck ^a	<input type="checkbox"/> sanofi ^b	<input type="checkbox"/> GSK ^c	<input type="checkbox"/> HepB-Hib	<input type="checkbox"/> DTaP-Hib	<input type="checkbox"/> DTaP-IPV-Hib ^d	<input type="checkbox"/> HibMenCY
	4			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Merck ^a	<input type="checkbox"/> sanofi ^b	<input type="checkbox"/> GSK ^c	<input type="checkbox"/> HepB-Hib	<input type="checkbox"/> DTaP-Hib	<input type="checkbox"/> DTaP-IPV-Hib ^d	<input type="checkbox"/> HibMenCY
	5			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Merck ^a	<input type="checkbox"/> sanofi ^b	<input type="checkbox"/> GSK ^c	<input type="checkbox"/> HepB-Hib	<input type="checkbox"/> DTaP-Hib	<input type="checkbox"/> DTaP-IPV-Hib ^d	<input type="checkbox"/> HibMenCY
^a PedvaxHIB [®] , PRP-OMP ^b ActHIB [®] , PRP-T ^c Hiberix [®] , booster, PRP-T ^d Pentacel											
Polio	1			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> IPV	<input type="checkbox"/> DTaP-HepB-IPV ^a	<input type="checkbox"/> DTaP-IPV-Hib ^b	<input type="checkbox"/> OPV			
	2			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> IPV	<input type="checkbox"/> DTaP-HepB-IPV ^a	<input type="checkbox"/> DTaP-IPV-Hib ^b	<input type="checkbox"/> OPV			
	3			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> IPV	<input type="checkbox"/> DTaP-HepB-IPV ^a	<input type="checkbox"/> DTaP-IPV-Hib ^b	<input type="checkbox"/> OPV			
	4			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> IPV	<input type="checkbox"/> DTaP-HepB-IPV ^a	<input type="checkbox"/> DTaP-IPV-Hib ^b	<input type="checkbox"/> OPV			
^a Pediarix ^b Pentacel											
Pneumococcal	1			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Conjugate-7 ^a	<input type="checkbox"/> Conjugate-13 ^b	<input type="checkbox"/> Polysaccharide ^c				
	2			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Conjugate-7 ^a	<input type="checkbox"/> Conjugate-13 ^b	<input type="checkbox"/> Polysaccharide ^c				
	3			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Conjugate-7 ^a	<input type="checkbox"/> Conjugate-13 ^b	<input type="checkbox"/> Polysaccharide ^c				
	4			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Conjugate-7 ^a	<input type="checkbox"/> Conjugate-13 ^b	<input type="checkbox"/> Polysaccharide ^c				
	5			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Conjugate-7 ^a	<input type="checkbox"/> Conjugate-13 ^b	<input type="checkbox"/> Polysaccharide ^c				
	6			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Conjugate-7 ^a	<input type="checkbox"/> Conjugate-13 ^b	<input type="checkbox"/> Polysaccharide ^c				
^a Prevnar [®] (PCV7) ^b Prevnar13 [®] (PCV13) ^c Pneumovax [®] (PPSV23)											
Rotavirus (RV)	1			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> RotaTeq [®] – Merck (RV5)	<input type="checkbox"/> Rotarix [®] – GSK (RV1)					
	2			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> RotaTeq [®] – Merck (RV5)	<input type="checkbox"/> Rotarix [®] – GSK (RV1)					
	3			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> RotaTeq [®] – Merck (RV5)	<input type="checkbox"/> Rotarix [®] – GSK (RV1)					
MMR	1			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MMR	<input type="checkbox"/> Measles only	<input type="checkbox"/> MMR-Varicella				
	2			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MMR	<input type="checkbox"/> Measles only	<input type="checkbox"/> MMR-Varicella				
Varicella	1			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Varicella only	<input type="checkbox"/> MMR-Varicella	<input type="checkbox"/> Child has a history of chickenpox				
	2			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Varicella only	<input type="checkbox"/> MMR-Varicella					
Hepatitis A	1			<input type="checkbox"/> Yes <input type="checkbox"/> No	Please remember to answer all questions on page 1.						
	2			<input type="checkbox"/> Yes <input type="checkbox"/> No							
Seasonal Influenza	1			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Inactivated Influenza Vaccine (IIV) ^a	<input type="checkbox"/> Live Attenuated Influenza Vaccine (LAIV) ^b					
	2			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Inactivated Influenza Vaccine (IIV) ^a	<input type="checkbox"/> Live Attenuated Influenza Vaccine (LAIV) ^b					
	3			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Inactivated Influenza Vaccine (IIV) ^a	<input type="checkbox"/> Live Attenuated Influenza Vaccine (LAIV) ^b					
	4			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Inactivated Influenza Vaccine (IIV) ^a	<input type="checkbox"/> Live Attenuated Influenza Vaccine (LAIV) ^b					
^a Injected, eg. Fluzone [®] ^b Inhaled nasal flu spray, eg. FluMist [®]											
Other	1			<input type="checkbox"/> Yes <input type="checkbox"/> No	} Please enter a description of each vaccine dose.						
	2			<input type="checkbox"/> Yes <input type="checkbox"/> No							
	3			<input type="checkbox"/> Yes <input type="checkbox"/> No							

If you need more space to report vaccines, please attach additional sheets.

Data Coll Period	Initial	Date
Progress		
MR or QX rcvd		
Trans complete		
Need Retrieval		
Retrieval Complete		
Edit Complete		
DE Vndr return		

Thank you!



Centers for Disease Control and Prevention

U.S. Department of Health and Human Services

Thank you for your help with this important study!

If you would like more information about the National Center for Immunization and Respiratory Diseases, including information about vaccine recommendations, or data and statistics from previous years of the National Immunization Survey, please visit the CDC Vaccines & Immunization website at www.cdc.gov/vaccines.

If you would like more information about the National Immunization Survey, please visit the National Immunization Survey website at <http://www.cdc.gov/vaccines/NIS>. If you have any questions or comments about this study, please call (800) 817-4316 or email nis@cdc.gov.

Note: Do NOT send any confidential patient information, such as patient's name or date of birth, in an email message.

Definitions:

Federally Qualified Health Center (FQHC): A Federally Qualified Health Center as defined under section 1905(l)(2) of the Social Security Act. FQHCs receive grants under Section 330 of the Public Health Service Act. (B) The term "Federally-qualified health center" means an entity which:
 (i) is receiving a grant under section 330 of the Public Health Service Act[282],
 (ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and
 (II) meets the requirements to receive a grant under section 330 of such Act.

Rural Health Clinic (RHC): A Rural Health Clinic as defined under section 1905(l)(1) of the Social Security Act. A Rural Health Clinic (RHC) is a clinic certified to receive special Medicare and Medicaid reimbursement.

FQHC Look-Alike: An organization that meets all of the eligibility requirements of an organization that receives a PHS Section 330 grant, but does not receive grant funding.