Iowa Department of Public Health
Master Index Card

Patient's Name: _____ SSN: _____ Date of Birth: _____ Gender: _____

Parent/Guardian: _____ Home Phone: _____ Birth State/Country: _____

Address: _____ Cell Phone: _____ Mother's Maiden Name: _____

E-mail: _____ Medicaid #: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐ Native Hawaiian or Other Pacific Islander ☐ White

Physician: _____

Medical Notes/Allergies: _____

This child qualifies for the VFC program because he/she is (select only one): ☐ M-Medicaid Enrolled ☐ NI-Has No Insurance ☐ AI/AN-Am. Ind/AK Native ☐ UI - Underinsured

*I have read and understand the appropriate Vaccine Information Statement(s). I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s).

Vaccine	Date Given	Client / Parent / Guardian Signature*	Health Care Provider	Dosage / Route / Site	Manufacturer / Lot #	VIS Date
Diphtheria, Tetanus, Pertussis DTaP/Tdap/DTP/DT/Td						
Polio IPV/OPV						
Measles, Mumps, Rubella MMR						
Haemophilus influenzae type b Hib						
Hepatitis B						

Revision date: 01/2017

Patient's Name: Date of Birth: Physician:

Vaccine	Date Given	Client / Parent / Guardian Signature*	Health Care Provider	Dosage / Route / Site	Manufacturer / Lot #	VIS Date
Varicella Chicken Pox/Shingles						
Pneumococcal PCV/PPSV						
Meningococcal MCV/MPSV/Mening B						
Hepatitis A						
Rotavirus						
HPV						
Influenza						
Other						

Health Care Provider	Initials	Health Care Provider	Initials

Notes / Comments:
