



Division of Disease Control, Bureau of Immunization
FLORIDA VACCINES FOR CHILDREN (VFC) PROGRAM
VACCINE REPORT FORM FAX TO: (850) 245-4734

DATE: _____

VFC PIN NUMBER (6 digit): _____

NAME OF PHYSICIAN'S OFFICE, PRACTICE, CLINIC, ETC. _____

CONTACT PERSON _____

DELIVERY ADDRESS (Number and Street—No P.O. Boxes) _____

TELEPHONE _____

Your designated ordering schedule is: B4: Bimonthly 16th through 31st of Feb / Apr / Jun / Aug / Oct / Dec

DOSES SHIPPED	A		B	C	D	E	F
Check if Vaccine Not Needed	Vaccine Name		Brand Name (Circle Choice)	Packaging (Check Preferred Presentation)	Number of Doses Used Since Last Order	Current Inventory	Returned Vaccines Since Last Order
	DT (PEDIATRIC)	DT	Sanofi Pasteur	<input type="checkbox"/> 10 single dose vials			
	DTaP	DD	Daptacel	<input type="checkbox"/> 10 single dose vials			
		DIV	Infanrix	<input type="checkbox"/> 10 single dose vials			
		DIS	Infanrix	<input type="checkbox"/> 10 single dose syringes			
		PES	Pediarix	<input type="checkbox"/> 5 single dose syringes			
	DTaP/HEP B/IPV	KV	Kinrix	<input type="checkbox"/> 10 single dose vials			
	DTaP/IPV	KS	Kinrix	<input type="checkbox"/> 5 single dose syringes			
		N	Pentacel	<input type="checkbox"/> 5 single dose vials			
	Hep A	HV	Havrix	<input type="checkbox"/> 10 single dose vials			
		HS	Havrix	<input type="checkbox"/> 10 single dose syringes			
		HVA	Vaqta	<input type="checkbox"/> 10 single dose vials			
	Hep B	HBV	Engerix B	<input type="checkbox"/> 10 single dose vials			
		HBS	Engerix B	<input type="checkbox"/> 10 single dose syringes			
		HBR	Recombivax	<input type="checkbox"/> 10 single dose vials			
	Hep B/Hib	C	Comvax	<input type="checkbox"/> 10 single dose vials			
	Hib	IA	ActHIB	<input type="checkbox"/> 5 single dose vials			
		IX	Hiberix	<input type="checkbox"/> 10 single dose vials			
		IP	PedvaxHIB	<input type="checkbox"/> 10 single dose vials			
	HPV-2	CV	Cervarix	<input type="checkbox"/> 10 single dose vials			
		CS	Cervarix	<input type="checkbox"/> 5 single dose syringes			
	HPV-4	G	Gardasil	<input type="checkbox"/> 10 single dose vials			
	IPV	EV	Ipol	<input type="checkbox"/> 10 dose multi-vials			
	MMR	M	MMRII	<input type="checkbox"/> 10 single dose vials			
	MMRV	PQ	ProQuad	<input type="checkbox"/> 10 single dose vials			
	MCV-4	MC	Menactra	<input type="checkbox"/> 5 single dose vials			
		MV	Menveo	<input type="checkbox"/> 5 single dose vials			
	PCV-13	PR	Prevnar 13	<input type="checkbox"/> 10 single dose syringes			
	PPSV	PP	Pneumovax	<input type="checkbox"/> 5 single dose vials			
	ROTA	RX	Rotarix	<input type="checkbox"/> 10 single dose vials			
		R	RotaTeq	<input type="checkbox"/> 10 single dose tubes			
	Td	TV	Decavac	<input type="checkbox"/> 10 single dose vials			
		TS	Decavac	<input type="checkbox"/> 10 single dose syringes			
	Tdap	PAV	Adacel	<input type="checkbox"/> 10 single dose vials			
		PAS	Adacel	<input type="checkbox"/> 5 single dose syringes			
		PBV	Boostrix	<input type="checkbox"/> 10 single dose vials			
		PBS	Boostrix	<input type="checkbox"/> 5 single dose syringes			
	VARICELLA	V	Varivax	<input type="checkbox"/> 10 single dose vials			

CHILDREN IMMUNIZED/VFC ELIGIBILITY	<1 Year	1-6 Years	7-10 Years	11-12 Years	13-18 Years	Total
<i>From Vaccine Usage Worksheet</i>						
Medicaid						
No Insurance						
Underinsured						
American Indian/Alaskan Native						

