Ohio Department of Health - Immunization Program

VACCINES FOR CHILDREN (VFC) PROGRAM

*2012-13 Influenza Accountability Sheet**

Immunization Program, 35 E. Chestnut, 6th Floor, Columbus, OH 43215

FAX: 614.564.2508

Please select month vaccine was administered	
❑ September	❑ January
❑ October	❑ February
❑ November	❑ March
❑ December	❑ April

Provider's Name	Contact Name	VFC provider number
Provider's Address	Telephone Number ( )	Medicaid number
City	Zip	

Please complete all sections on this form

Patient Name	Date of Birth	Date of Service (month/day)	PATIENT ELIGIBILITY STATUS and VACCINE DOSES ADMINISTERED								
			Preservative Free (TIV) (.25 ml dose) VFC Only 6-35 mo.			Non-Preservative Free (TIV) (0.5 ml dose) VFC Only 3-18 yrs.			Flu Mist (LAIV) (Single dose) Healthy Children Only VFC Only 2-18 yrs.		
			MEDICAID & MED. HMO'S	NO INSURANCE (Self pay)	NATIVE AMER or ALASKAN	MEDICAID & MED. HMO'S	NO INSURANCE (Self pay)	NATIVE AMER or ALASKAN	MEDICAID & MED. HMO'S	NO INSURANCE (Self pay)	NATIVE AMER or ALASKAN
1	/ /	/									
2	/ /	/									
3	/ /	/									
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14	/ /	/									
15	/ /	/									
TOTAL *DOSES GIVEN FOR EACH CATEGORY* **:** (i.e., add doses given in all eligibility categories for preservative-free syringe 6-35 months)											

Provider's signature: **Date:** / /

**Sheets to be kept on file for 6 years*