Smallpox Vaccine Record of Immunization

Name: ____

Patient Identifying Number: PVN______________________________

Address: ____

____
(City) (State) (Zip Code)

Telephone: (_____) ______________________

BELOW TO BE FILLED OUT BY VACCINE ADMINISTRATORS

Date (mm/dd/yy)	**Vaccine Type** (check type)	**Vaccine LOT#**	**Vaccination Site** (check box)	**Clinic Name**	**Person Administering Vaccine**	**VIS Publication Date**
	Dryvax • **Aventis** • **ACAM1000** • **ACAM2000** •		**Right arm** • **Left arm** • **Other** •			
	Dryvax • **Aventis** • **ACAM1000** • **ACAM2000** •		**Right arm** • **Left arm** • **Other** •			
	Dryvax • **Aventis** • **ACAM1000** • **ACAM2000** •		**Right arm** • **Left arm** • **Other** •			
	Dryvax • **Aventis** • **ACAM1000** • **ACAM2000** •		**Right arm** • **Left arm** • **Other** •			

Take Response

Take Response exam performed by: ________________________________

Exam date: ____________________

___Major
___Equivocal
___No Take