

Due 5th of EACH Month

MONTHLY VACCINE REPORT FORM (Public)

VFC ID # _____

Name of Facility: _____ Person Filing: _____ Phone number: _____ Month: _____
 Year: _____

Vaccine	Doses on Hand Beg. of Month	Doses Rec. During Month	Doses Lost or Returned to State	Total Doses Available	Doses Administered By Age (In Years) Mandatory											Total Each Row	Total Doses Each Vaccine	Doses on Hand End of Month	Lot Num and Outdate
					<1	1	2	3-4	5	6-9	10-14	15-19	20-24	25-44	45-64				
DTaP																	Total DTaP ↓		
DTaP/ IPV																	Total DTaP/ IPV ↓		
DTaP/IPV/ HIB																	Total DTaP/IPV/ HIB ↓		
DTaP/IPV/ Hep B																	Total DTaP/ IPV/Hep B ↓		
IPV																	Total IPV ↓		
HIB																	Total HIB ↓		
Pneumo (PCV7)																	Total PCV7 ↓		
PPV (23) High Risk																	Total PPV (23) ↓		
Rotavirus 2-dose																	Total Rota ↓		
Rotavirus 3-dose																	Total Rota ↓		

MAIL ONLY: (If you fax you must mail a copy also) to Home IV Pharmacy, 2601 ½ Continental, Butte, MT 59701

PHHS-111 DPHHS (Revised 10/7/2008)

Facility Name: _____

Facility Address: _____

Phone: _____

VFC ID # _____

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					<1	1	2	3-4	5	6-9	10-14	15-19	20-24	25-44	45-64	65+				
MMR																		Total MMR ↓		
Varicella																		Total Var ↓		
Tdap																		Total Tdap ↓		
Td																		Total Td ↓		
Mening																		Total Mening ↓		
HPV																		Total HPV ↓		
Hep A																		Total Hep A ↓		
Hep A Adult																		Total Hep A Adult ↓		
Hep B																		Total Hep B ↓		
Hep B Adult																		Total HepB Adult ↓		
HepA/HepB (Twinrix)																		Total HepA/Hep B ↓		
Other																		Total Other ↓		

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					<1	1	2	3-4	5	6-9	10-14	15-19	20-24	25-44	45-64	65+				
Flu .25 infant																		Total .25 Flu ↓		
Flu .50																		Total .5 Flu ↓		
Flumist																		Total Flumist ↓		
Flu Multi-Dose Vials																		Total Flu Multi-dose ↓		
Other																		Other ↓		

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