

Vaccine Administration Visit Record (VAVR)
Demographic and Consent Language

Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female				M M / D D / Y Y	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Child's Last Name	Child's First Name	MI <input type="text"/>	Child's Date of Birth		
<input type="text"/>	<input type="text"/>	MI <input type="text"/>	Please check box if child is a:		
Mother's Last Name	Mother's First Name		<input type="checkbox"/> Twin <input type="checkbox"/> Triplet		
<input type="text"/>	<input type="text"/>				
Child's Mother's Maiden Name	Child's Mother's Date of Birth				
<input type="text"/>	<input type="text"/>				
Child's Mailing Address					
<input type="text"/>	<input type="text"/>	<input type="text"/>	(<input type="text"/>)	-	<input type="text"/>
City	State	Zip Code	Phone Number		
<input type="text"/>					
E-mail Address					
<input type="text"/>					
Child's Doctor's Last Name			Child's Doctor's First Name		
<input type="text"/>			<input type="text"/>		
I have received and read the current Hepatitis B Vaccine Information Statement. In addition, I have received information regarding the Hawaii Immunization Registry (see reverse side).					
Signature of Parent/Legal Guardian: _____				Date: ____/____/____	

I have received and read the Vaccine Information Statements for each of the vaccines to be administered. In addition, I have received information regarding the Hawaii Immunization Registry (see reverse side).					
Signature of Parent/Legal Guardian: _____				Date: ____/____/____	