

**Please review the instructions and examples below.
Then complete the “Shot Grid” on the next page.**

Refer to your vaccination records for the adolescent named on the labels on the front cover and next page of this form.

- ▶ Record the month, day and year that each type of shot was given.

EXAMPLE

Vaccine	Date Given			Given by Other Practice?		Type of Vaccine			
	Month	Day	Year	Yes	No	<i>Mark one box for each vaccine dose received after age 6</i>			
Td/Tdap boosters received after age 6	1	11	18	2002	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Td	<input type="checkbox"/> Tdap (Adacel® or Boostrix®)	
	2				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Td	<input type="checkbox"/> Tdap (Adacel® or Boostrix®)	
	3				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Td	<input type="checkbox"/> Tdap (Adacel® or Boostrix®)	
MMR	1				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> MMR	<input type="checkbox"/> MMR-Varicella	<input type="checkbox"/> Measles only
	2	9	20	2002	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> MMR	<input type="checkbox"/> MMR-Varicella	<input type="checkbox"/> Measles only

- ▶ Be sure to mark the “Yes” or “No” box under “Given by other practice?” for vaccinations given by another practice (see example above).
- ▶ Use the “Other” space to enter any vaccines not listed on the next page or any additional doses of listed vaccines that were given to this adolescent (see example below)

Other or additional doses of vaccines listed above	1	11	20	2001	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	} Please do not record Polio, Hib, or any Pneumococcal vaccine given before 5 years old.	Please enter a description of each vaccine dose	
	2				<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="text" value="TYPHOID"/> <input type="text"/>	

- ▶ After completing the “Shot Grid” on the next page, please return this form in the envelope provided.
- (Optional) You may also attach a copy of your immunization history records for this adolescent to this form and send it back to

NORC at the University of Chicago
National Immunization Survey – Teen
300 East Randolph Street, Suite 4600
Chicago, IL 60601

Or you may fax the confidential information to (866) 324-8659. If faxing this form, cut along fold to separate pages, then fax pages 1 and 3. Do not fax this page.

National Immunization Survey – Teen

Please record all vaccination dates in your records for these vaccine types. We realize you might not have the full immunization history of this adolescent.

Vaccine	Date Given			Given by Other Practice?		Type of Vaccine					
	Month	Day	Year	Yes	No	Mark one box for each vaccine dose received after age 6					
Td/Tdap boosters received after age 6	1	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Td	<input type="checkbox"/> Tdap (Adacel® or Boostrix®)				
	2	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Td	<input type="checkbox"/> Tdap (Adacel® or Boostrix®)				
	3	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Td	<input type="checkbox"/> Tdap (Adacel® or Boostrix®)				
Hepatitis B received since birth	Mark one box for each vaccine dose										
	1	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0.5 ml Recombivax®	<input type="checkbox"/> 1.0 ml Recombivax®	<input type="checkbox"/> Engerix®	<input type="checkbox"/> HepB only - unknown type		<input type="checkbox"/> HepB-Hib
	2	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0.5 ml Recombivax®	<input type="checkbox"/> 1.0 ml Recombivax®	<input type="checkbox"/> Engerix®	<input type="checkbox"/> HepB only - unknown type		<input type="checkbox"/> HepB-Hib
	3	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0.5 ml Recombivax®	<input type="checkbox"/> 1.0 ml Recombivax®	<input type="checkbox"/> Engerix®	<input type="checkbox"/> HepB only - unknown type		<input type="checkbox"/> HepB-Hib
4	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0.5 ml Recombivax®	<input type="checkbox"/> 1.0 ml Recombivax®	<input type="checkbox"/> Engerix®	<input type="checkbox"/> HepB only - unknown type		<input type="checkbox"/> HepB-Hib	
Seasonal Influenza received in the past three years	Mark one box for each vaccine dose										
	1	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Inactivated Influenza Vaccine (IIV) ^a		<input type="checkbox"/> Live Attenuated Influenza Vaccine (LAIV) ^b			
	2	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Inactivated Influenza Vaccine (IIV) ^a		<input type="checkbox"/> Live Attenuated Influenza Vaccine (LAIV) ^b			
3	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Inactivated Influenza Vaccine (IIV) ^a		<input type="checkbox"/> Live Attenuated Influenza Vaccine (LAIV) ^b				
<small>^aInjected, eg. Fluzone®, Fluvirin®, Fluarix®, Afluria®, FluLaval®, Flucelvax® ^bInhaled nasal flu spray, eg. FluMist®</small>											
MMR	Mark one box for each vaccine dose										
	1	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> MMR	<input type="checkbox"/> MMR-Varicella	<input type="checkbox"/> Measles only			
2	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> MMR	<input type="checkbox"/> MMR-Varicella	<input type="checkbox"/> Measles only				
Varicella	Mark one box for each vaccine dose										
	1	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Varicella only	<input type="checkbox"/> MMR-Varicella				
2	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Varicella only	<input type="checkbox"/> MMR-Varicella					
<input type="checkbox"/> Child has a history of chickenpox											
Hepatitis A	Mark one box for each vaccine dose										Please remember to answer all questions on page 1.
	1	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> HepA only (Havrix® or Vaqta®)					
	2	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> HepA only (Havrix® or Vaqta®)					
3	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> HepA only (Havrix® or Vaqta®)						
Meningococcal serogroups ACWY	Mark one box for each vaccine dose										
	1	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> MCV4 or MenACWY (Menactra®, Menveo® or MenQuadfi®)	<input type="checkbox"/> MPSV4 (Menomune®)	<input type="checkbox"/> MenABCWY (Penbraya®)	<input type="checkbox"/> MenABCWY (Penmenvy®)		
2	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> MCV4 or MenACWY (Menactra®, Menveo® or MenQuadfi®)	<input type="checkbox"/> MPSV4 (Menomune®)	<input type="checkbox"/> MenABCWY (Penbraya®)	<input type="checkbox"/> MenABCWY (Penmenvy®)			
Meningococcal serogroup B	Mark one box for each vaccine dose										
	1	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> MenB-FHbp (Trumenba®)	<input type="checkbox"/> MenB-4C (Bexsero®)	<input type="checkbox"/> MenABCWY (Penbraya®)	<input type="checkbox"/> MenABCWY (Penmenvy®)		
	2	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> MenB-FHbp (Trumenba®)	<input type="checkbox"/> MenB-4C (Bexsero®)	<input type="checkbox"/> MenABCWY (Penbraya®)	<input type="checkbox"/> MenABCWY (Penmenvy®)		
3	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> MenB-FHbp (Trumenba®)	<input type="checkbox"/> MenB-4C (Bexsero®)	<input type="checkbox"/> MenABCWY (Penbraya®)	<input type="checkbox"/> MenABCWY (Penmenvy®)			
Human papillomavirus (HPV)	Mark one box for each vaccine dose										
	1	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Gardasil® (4vHPV)	<input type="checkbox"/> Gardasil® 9 (9vHPV)	<input type="checkbox"/> Cervarix® (2vHPV)			
	2	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Gardasil® (4vHPV)	<input type="checkbox"/> Gardasil® 9 (9vHPV)	<input type="checkbox"/> Cervarix® (2vHPV)			
3	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Gardasil® (4vHPV)	<input type="checkbox"/> Gardasil® 9 (9vHPV)	<input type="checkbox"/> Cervarix® (2vHPV)				
COVID-19 Vaccine	Mark one box for each vaccine dose										Please specify brand
	1	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Pfizer-BioNTech®	<input type="checkbox"/> Moderna®	<input type="checkbox"/> Novavax®	<input type="checkbox"/> OTHER →		<input type="text"/>
	2	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Pfizer-BioNTech®	<input type="checkbox"/> Moderna®	<input type="checkbox"/> Novavax®	<input type="checkbox"/> OTHER →		<input type="text"/>
	3	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Pfizer-BioNTech®	<input type="checkbox"/> Moderna®	<input type="checkbox"/> Novavax®	<input type="checkbox"/> OTHER →		<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Pfizer-BioNTech®	<input type="checkbox"/> Moderna®	<input type="checkbox"/> Novavax®	<input type="checkbox"/> OTHER →		<input type="text"/>	
Other or additional doses of vaccines listed above	Mark one box for each vaccine dose										Please enter a description of each vaccine dose
	1	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Please do not record Polio, Hib, or any Pneumococcal vaccine given before 5 years old.				<input type="text"/>	
	2	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="text"/>	
	3	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="text"/>	
	4	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="text"/>	
5	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>						

If you need more space to report vaccines, please attach additional sheets.

For Office Use Only

Data Coll Period	Initial	Date
Progress		
MR or QX rcvd		
Trans complete		
Need Retrieval		
Retrieval Complete		
Edit Complete		
DE Vndr return		

Thank you!



Centers for Disease Control and Prevention

U.S. Department of Health and Human Services

Thank you for your help with this important study!

If you would like more information about the National Center for Immunization and Respiratory Diseases, including information about vaccine recommendations, please visit the CDC Vaccines & Immunization website at www.cdc.gov/vaccines.

If you would like more information about the National Immunization Survey, including data and statistics from previous years, please visit the National Immunization Survey website at <https://www.cdc.gov/nis/about/index.html>. If you have any questions or comments about this study, please call (800) 817 4316 or email nis@cdc.gov.

If you would prefer the study team to send immunization history requests via encrypted email, please reach out to us at NISProvider@norc.org.

Note: Do NOT send any confidential patient information, such as patient's name or date of birth, in an email message.

Definitions:

Federally Qualified Health Center (FQHC): A Federally Qualified Health Center as defined under section 1905(l)(2) of the Social Security Act. FQHCs receive grants under Section 330 of the Public Health Service Act. (B) The term "Federally-qualified health center" means an entity which:
(i) is receiving a grant under section 330 of the Public Health Service Act[282],
(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and
(II) meets the requirements to receive a grant under section 330 of such Act.

Rural Health Clinic (RHC): A Rural Health Clinic as defined under section 1905(l)(1) of the Social Security Act. A Rural Health Clinic (RHC) is a clinic certified to receive special Medicare and Medicaid reimbursement.

FQHC Look-Alike: An organization that meets all of the eligibility requirements of an organization that receives a PHS Section 330 grant, but does not receive grant funding.