

Report Period: _____
 Clinic Name: _____
 Person Completing Report: _____

**Required Monthly State
 Vaccine Report**

WCHD
 Phone: 676-4593 Fax: 676-6772

VACCINE	BEGINNING OF MONTH INVENTORY	VACCINE ADDED THIS MONTH	LOT #s	END OF MONTH INVENTORY (Physical count)	LOT #s	EXPIRATION DATE	VACCINE WASTED OR EXPIRED, VIABLE or TRANSFERRED	VARIANCE: DOSES GAINED (+) or LOST (-)
DT (Ped)								
DTap								
DTap/IPV/Hep B (Pediarix)								
DTaP/IPV-Hib (Pentacel)								
DTap/IPV (Kinrix)								
Hep A (Ped)								
Hep B (Ped)								
HepB/Hib (Comvax)								
Hib								
HPV								
IPV								
MCV								
MMR								
MMRV								
PCV								
PPSV								
Rotavirus								
Td								
Tdap								
Varicella								
Influenza PF 0.25ml (6 to 35 months)								
Influ MD 5.0 ml Vial (3 up to 19 th BD)								
Influ-PF 0.5ml Pregnant Teen Only								
FluMist .02ml (2 up to the 19 th BD)								