

# VACCINES FOR CHILDREN (VFC) PROGRAM VACCINE ORDER FORM

PIN (6 digit) \_\_\_\_\_

COUNTY \_\_\_\_\_

NAME OF PHYSICIAN'S OFFICE, PRACTICE, CLINIC, ETC. \_\_\_\_\_ DATE \_\_\_\_\_ CHDP MEDI-CAL PROVIDER  
 Yes  No

DELIVERY ADDRESS (Number and Street—No P.O. Boxes) \_\_\_\_\_  CHECK HERE IF THIS IS A NEW ADDRESS. CITY \_\_\_\_\_ ZIP CODE \_\_\_\_\_

**DELIVERY:** Please specify all days and times you may receive vaccine.  DAY AND TIME  Tue. \_\_\_\_\_ DAY AND TIME  Wed. \_\_\_\_\_ DAY AND TIME  Thu. \_\_\_\_\_ DAY AND TIME  Fri. \_\_\_\_\_

CONTACT PERSON \_\_\_\_\_ TELEPHONE \_\_\_\_\_ FAX \_\_\_\_\_

Vaccines <sup>1</sup> Write in the name of the manufacturer you prefer (if any) for DTaP, hepatitis A, hepatitis B, Hib, and Tdap vaccines in the indicated spaces below.	YOU MUST COMPLETE ALL THE BOXES IN THE FOUR COLUMNS BELOW FOR VFC TO PROCESS YOUR ORDER. (EVEN IF YOU ARE ONLY ORDERING ONE VACCINE)			Vaccine Shipped in Vials of the Following Sizes	New Vaccine Order (Minimum 10 doses except LAIV 20 doses minimum) Order in multiple of 10 doses
	Number of Doses (VFC Only) Used Since Last Order Enter "0" if None	VACCINE INVENTORY			
		Number of Doses (VFC Only) On-Hand	Lot Number	Expiration Date	

REGULAR ORDER VFC VACCINES					
<b>DTaP</b> (Preferred Mfr.: _____)					10 x 1 dose vial _____ doses
<b>DTaP/Hepatitis B/IPV Combination</b>					10 x 1 dose vial _____ doses
<b>Hepatitis A</b> (Age 12 months–18 years) (Preferred Mfr.: _____)					10 x 1 dose vial _____ doses
<b>Hepatitis B</b> (Pediatric/Adolescent) (Preferred Mfr.: _____)					10 x 1 dose vial _____ doses
<b>Hepatitis B/Hib Combination</b>					10 x 1 dose vial _____ doses
<b>Hib</b> (Preferred Mfr.: _____)					10 x 1 dose vial 5 x 1 dose vial _____ doses
<b>IPV</b> (Inactivated Polio Vaccine)					10 dose vial _____ doses
<b>MMR</b> (Combined Measles, Mumps, and Rubella)					10 x 1 dose vial _____ doses
<b>Meningococcal Conjugate</b> (ONLY for adolescents 11–18 years of age)					5 x 1 dose vial _____ doses
<b>Pneumococcal Conjugate</b>					5 x 1 dose vial _____ doses
<b>Td–Preservative Free</b> (Age 7–18 years)					10 x 1 dose syringe no needle _____ doses
<b>Tdap</b> (Adolescent Td with acellular pertussis [booster] ages 10-18 years) (Preferred Mfr.: _____)					10 x 1 dose vial _____ doses
<b>Varicella</b> (Chickenpox)					10 x 1 dose vial _____ doses

**IMPORTANT**  **IF THE SPECIFIC VACCINE MANUFACTURERS I HAVE INDICATED ABOVE ARE NOT AVAILABLE:**  
 Send another manufacturer's vaccine.  Send the manufacturer's vaccine I requested when it is available.

SPECIAL ORDER VFC VACCINES (These vaccines are available only for special circumstances.)					
<b>Influenza–Preservative Free</b> (Order Aug.–Jan.) (Licensed for use 6–35 months of age)					10 x 1 Tip Lok® no needle syringe _____ doses
<b>Influenza</b> (Order Aug.–Jan. for ACIP rec. VFC children 36 months–18 years of age)					10 dose vial _____ doses
<b>LAIV–Intranasal</b> (Order Aug.–Jan. for ACIP rec. HEALTHY children 5–18 years of age)					10 pack x 1 dose sprayers _____ doses

**Notes:** Toxoids and vaccines not available through the VFC Program: DT–Pediatric, DTaP–Hib, OPV, tetanus, measles, MR (measles-rubella), mumps, and rubella vaccines, HBIG, and PPD.

**Instructions:** 1. Please Print or Type.  
 2. Order no more than once every two months (i.e., no more than six times per year). Place your order with sufficient stock on hand to allow at least 30 days for delivery. (It should not take 30 days to deliver vaccine, but this will prevent you from running out of vaccine if there is a delay in filling your order.)  
 3. Fax your order to the VFC Program.  
**Questions:** Toll-free: 877-2Get-VFC (877-243-8832)  
**FAX orders to:** Toll-free: 877-FAXX-VFC (877-329-9832)

STATE USE ONLY	
ASSIGNED	_____
APPROVED	_____
ASSIGNED	_____
ENTERED	_____
SHIPPED	_____

VFC Program  
 California Department of Health Services, Immunization Branch  
 850 Marina Bay Parkway, Building P • Richmond, CA 94804

