Vaccine Usage Logs

Instruction: Click to select a vaccine usage log by funding source.

VFC Program

Includes option for private vaccines.

1. Daily Usage Log (pediatric & adolescent/high-risk)
2. Influenza Usage Log (pediatric)

VFA & LHD 317 Programs

Includes option for private vaccines.

1. Daily Usage Log (adults)

SGF Program

1. Daily Usage Log & Influenza Authorization (English & Spanish) (all)
2. Daily Usage Log for Outbreaks (all)

California Department of
Public Health

Vaccines for Children (VFC) Program — Daily Usage Log (Pediatric)

Select one: ☐ VFC vaccines ☐ Private vaccines

Instructions: Keep log near vaccines. Record date, patient info, and doses administered. At end of day, record daily totals and report to CAIR or CAIR/ Healthy Futures. Keep usage logs for three years.

Patient Name (or medical record #)	Date of Birth	REFRIGERATED															FROZEN			
		COVID-19	DTaP	DTaP-IPV	DTaP-IPV-HepB	DTaP-IPV-Hib	DTaP-IPV-Hib-HepB	HepA	HepB	Hib	IPV	MMR	PCV 15	PCV 20	RSV	RV	COVID-19	MMR	MMRV	VAR
		Comirnaty Nuvaxovid Spikevax	Daptacel Infanrix	Kinrix Quadracel	Pediarix	Pentacel	Vaxelis	Havrix VAQTA	Energix-B Heplisav-B Recombivax HB	ActHIB Pedvax-HIB	IPOL	Priorix only	Vaxneu-vance	Prevnar 20	Beyfortus Enflonsia	Rotarix RotaTeq	Spikevax only	MMR II only	ProQuad	Varivax
Daily Totals:																				

Staff Name: _____ Date: _____ Date Doses Reported to Registry: _____ PAGE _____ OF _____

California Department of Public Health

Vaccines for Children (VFC) Program Daily Usage Log (Adolescent/High-Risk)

Select one:
☐ **VFC vaccines** ☐ **Private vaccines**

Instructions: Keep log near vaccines. Record date, patient info, and doses administered. At end of day, record daily totals and report to CAIR or CAIR/Healthy Futures. Keep usage logs for three years.

Patient Name (or medical record #)	Date of Birth	REFRIGERATED									
		HepA-HepB	**HPV**	**MenABCWY**	**MenACWY/ MCV4**	**MenB**	**Mpox**	**PPSV23**	**RSV**	**Td**	**Tdap**
		Twinrix	Gardasil 9	Penbraya Penmenvy	MenQuadfi Menveo	Bexsero Trumenba	JYNNEOS	Pneumovax 23	Abrysvo	Tenivac	Adacel Boostrix
Daily Total:											

Staff Name: _____ **Date:** _____ **Date Doses Reported to Registry:** _____ **PAGE** ____ **OF** ____

California Department of Public Health

Vaccines for Children (VFC) Program — Influenza Usage Log (Pediatric)

Select one:
☐ VFC vaccines ☐ Private vaccines

INSTRUCTIONS: Keep log near vaccines. Record date, patient info, and doses administered. At end of day, record daily totals and report to CAIR or CAIR/Healthy Futures. Keep usage logs for three years.

Patient Name (or medical record #)	Date of Birth	Fluarix® 0.5 mL syringes	Flulaval® 0.5 mL syringes	Fluzone® 0.5 mL syringes	Flumist® 0.2 mL sprayer	Flucelvax® 0.5 mL syringes			
Daily Total:									

Staff Name: _____ Date: _____ Date Doses Reported to Registry: _____ PAGE _____ OF _____

INSTRUCTIONS: Keep log near vaccines. Record date, patient info, and doses administered. At end of day, record daily totals and report to CAIR or CAIR/Healthy Futures. Keep usage logs for three years.

Patient Name (or medical record #)	Date of Birth	REFRIGERATED											FROZEN		
		COVID-19	HepA	HepB	HPV	IPV (LHD 317)	MenACWY	MMR	PCV20	PCV21	RSV	Tdap	COVID-19	MMR	VAR
		Comirnaty Nuvaxovid Spikevax	Havrix VAQTA	Engerix B Heplisav-B Recombivax HB	Gardasil 9	IPOL	MenQuadfi Menveo	Priorix only	Prevnar20	Capvaxive	Abrysvo Arexvy mRESVIA	Adacel Boostrix	Spikevax only	MMR-II only	Varivax
Daily Total:															

Staff Name: _____   Date: _____   Date Doses Reported to Registry: _____   PAGE ____ OF ____

California Department of Public Health

Daily Usage Log & Influenza Authorization

SGF State General Fund Vaccine

This form must be signed on date vaccine is administered by recipient or parent, guardian, or another authorized person.

I read or had explained to me the "Influenza Vaccine Information Statement." I had an opportunity to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and request that it to be given to me or to the person for whom I am authorized to make this request.

Signature of recipient (or authorized person and name of recipient)	Site	VFC-Eligible Y/N	Age (check one column only)						
			6-35 mo	3-6 yrs	7-18 yrs	19-49 yrs	50-59 yrs	60-64 yrs	65+ yrs
TOTAL DOSES ADMINISTERED									

To be returned to your Immunization Coordinator by: (Date)_____

Manufacturer and Lot No. _____   Contact Person _____

Clinic Identification _____   Telephone _____

Date _____   Date Doses Reported to Registry: _____

California Department of Public Health

Registro de uso diario y autorización para la influenza

La persona recibiendo la vacuna, su padre o tutor u otra persona autorizada debe firmar este formulario en la fecha en que se administra la vacuna.

Atestación: He leído o me han explicado la «Declaración de información de la vacuna contra la influenza». Tuve la oportunidad de hacer preguntas que fueron respondidas a mi satisfacción. Creo que comprendo los beneficios y riesgos de la vacuna contra la influenza y solicito que se me administre a mí o a la persona para la que estoy autorizado a hacer esta solicitud.

Firma de la persona que se vacuna (o de la persona autorizada y el nombre de la persona que se vacuna)	Site	VFC Eligible Y/N	Age (check one column only)						
			6-35 mo	3-6 yrs	7-18 yrs	19-49 yrs	50-59 yrs	60-64 yrs	65+ yrs
TOTAL DOSES ADMINISTERED									

To be returned to your Immunization Coordinator by: (Date)_____

Manufacturer and Lot No. _____   Contact Person _____

Clinic Identification _____   Telephone _____

Date _____   Date Doses Reported to Registry: _____

SGF | **Daily Usage Log for Outbreaks**

Select one:
☐ SGF vaccines ☐ Private vaccines

INSTRUCTIONS: Keep log near vaccines. Record date, patient info, vaccine brand, and doses administered. At end of day, add up daily totals and report to CAIR or CAIR/Healthy Futures.

Patient Name (or medical record #)	Date of Birth	Write in vaccine brand				
Daily Total:						

Staff Name: _____ Date: _____ Date Doses Reported to Registry: _____ PAGE _____ OF _____

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