DO NOT SEND **PROVIDER USE ONLY**

VFC ACTIVITY WORKSHEET

VFC PIN # _____ **Provider Name** _____ **Start Date** _____ **End Date** _____ .

For each child please indicate appropriate eligibility status.*			DT	DTaP	IPV	HEP A	HEP B Adult	HEP B PF	HEPB-Hib	Hib	HPV	Influenza	MMR	MMRV	MCV4	MPSV4	Pediarix	PNEUMO	Prevnar	Rotavirus	Td Adult	Tdap	Varicella
<1 year	1-6 yrs	7-18 yrs																					

*Indicate eligibility status by entering: **M**edicaid, **U**ninsured (No Insurance), American **I**ndian, **A**laska Native, u**N**der-insured, **K**CHIP, **O**ther

Kentucky Immunization Program
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Instructions on Reverse