

INSTRUCTIONS FOR COMPLETION OF THE VACCINE ADMINISTRATION RECORD AND TUBERCULOSIS TESTING RECORD (CH-2A)

Purpose

The Vaccine Administration Record and Tuberculosis Testing Record (CH-2A) is required to be used for all immunizations and tuberculosis testing.

Initiation, Maintenance, and Instructions for Completion

When filed in the folder, only the patient's name, birth date, and patient ID number are required for identifying information.

Immunization documentation must consist of: date, manufacturer, lot number, injection site, and provider initials in the appropriate space for vaccine type and specific dose.

To provide a complete immunization record, enter immunizations, which the patient received from providers outside of the LHD in red ink.

For tuberculosis testing, enter the testing date, test type and manufacturer, lot number, provider initials, reading date (only for TST), results, and provider initials in appropriate boxes. A TB Risk Assessment shall be performed on all persons who have TB testing in local health departments.

The Vaccine Administration Record and Tuberculosis Testing Record is a permanent record, therefore, when the medical record reaches its retention period, the CH-2A must be removed and the most current demographic information, i.e., sex, race, address, etc. should be recorded on the immunization card.

If the Vaccine Administration Record and Tuberculosis Testing Record is being used as a stand-alone record, i.e., patient does not have a folder, the following data elements are required: patient's name, address, sex, race, birth date, mother, father, spouse, legal guardian (when applicable), and patient's ID number. All other instructions for documentation of immunizations and tuberculosis testing are as stated above.

Note

Provider initials used for signing on the Vaccine Administration Record and Tuberculosis Testing Record must be listed on the Provider's Legend maintained in the administrative files of the LHD.