U.S. Department of State

# VACCINATION DOCUMENTATION WORKSHEET

For Use with DS-2053 To Be Completed by Panel Physician Only

OMB No. 1405-0113
EXPIRATION DATE: 05/31/2007
ESTIMATED BURDEN: 20 minutes
(See Page 2 - Back of Form)

| Name *(Last, First, MI)* | | Exam Date *(mm-dd-yyyy)* |
|---|---|---|
| Birth Date *(mm-dd-yyyy)* | Passport Number | Alien (Case) Number |

REQUIRED FOR U.S. IMMIGRANT VISA APPLICANTS

NOT REQUIRED FOR REFUGEE APPLICANTS

NOTE FOR PANEL PHYSICIANS:
For refugee applicants, please complete only if reliable vaccination documents are available

1. Immunization Record

| Vaccine | Vaccine History Transferred From a Written Record *(list chronologically from left to right)* Date received *(mm-dd-yyyy)* | Date received *(mm-dd-yyyy)* | Date received *(mm-dd-yyyy)* | Date received *(mm-dd-yyyy)* | Vaccine Given by Panel Physician *(mm-dd-yyyy)* | Completed Series *(✓ if completed, write "VH" if varicella history, or write date of lab test if immune)* | Blanket Waiver(s) To Be Requested If Vaccination Not Medically Appropriate, Check Suitable Box(es) Below: Not age appropriate | Insufficient time interval | Contra-indicated | Not routinely available | Not fall (flu) season |
|---|---|---|---|---|---|---|---|---|---|---|---|
| DT/DTP/DTaP | | | | | | | | | | | |
| Td | | | | | | | | | | | |
| Polio (OPV/IPV) | | | | | | | | | | | |
| Measles (or MR or MMR) | | | | | | | | | | | |
| Mumps (or MMR) | | | | | | | | | | | |
| Rubella (or MR or MMR) | | | | | | | | | | | |
| Hib *(Haemophilus influenzae type b)* | | | | | | | | | | | |
| Hepatitis B | | | | | | | | | | | |
| Varicella | | | | | | | | | | | |
| Pneumococcal | | | | | | | | | | | |
| Influenza | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

2. Results

- ☐ Vaccine history incomplete
  - ☐ Applicant may be eligible for blanket waiver(s) because vaccination(s) not medically appropriate *(as indicated above)*.
  - ☐ Applicant will request an individual waiver based on religious or moral convictions.
- ☐ Vaccine history complete for each vaccine, all requirements met *(documented above)*.
- ☐ Applicant does not meet vaccination requirements for one or more vaccines and no waiver is requested.

3. Panel Physician *(name)* _____

Panel Physician *(signature)* _____

Date *(mm-dd-yyyy)* _____

## PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

**Public reporting burden for this collection of information is estimated to average 20 minutes per response, including time required for searching existing data sources, gathering the necessary data, providing the information required, and reviewing the final collection. Persons are not required to provide this information in the absence of a valid OMB approval number. Send comments on the accuracy of this estimate of the burden and recommendations for reducing it to: the U.S. Department of State (A/RPS/DIR) Washington, DC 20520.**

**We ask for the information on this form in the case of applicants for immigrant visas to determine medical eligibility under INA Sections 212(a) and 221(d) and as required by INA Section 212(g)(2). If an immigrant visa is issued, you will convey this form to the Department of Homeland Security (DHS) for disclosure to the Center for Disease Control and the Public Health Service. Failure to provide this information may delay or prevent the processing of your case. If your Immigrant visa is not issued, this form will be treated as confidential under INA Section 222(f).**