

A1. Site/Study ID #: _____ / _____

A2. Date: _____ / _____ / _____
Month Day Year

A3. Staff Initials: _____

A4. Age: _____ mo/yr

To DCC **SECTION C**

C1. Vaccine Antigen	Protective Titer	Titer Result
a. Hepatitis B	≥ 10 IU/ml	IU/ml ZVTC1ATR V2(10)
b. Diphtheria	≥ 0.1 IU/ml	____ . ____ IU/ml ZVTCIBTR V2(10)
c. Tetanus	≥ 0.1 IU/ml	____ . ____ IU/ml ZVTCICTR V2(10)
d. H. influenzae type B	1 ug/ml	____ ug/ml ZVTCIDTR V2(10)
e. Poliovirus type 1	1:100	____ : ____ ZVTCIETR V2(10)
f. Poliovirus type 2	1:100	____ : ____ ZVTCIFTR V2(10)
g. Poliovirus type 3	1:100	____ : ____ ZVTCIGTR V2(10)

SECTION D

- D1. All antibody titers were protective 1. No 2. Yes → End ZVTD01AP V2(2)
- a. Primary care physician was notified 1. No 2. Yes → Go to D1c ZVTD01pc V2(2)
- b. If not notified, reason: ZVTD01BR V2(300)
- c. Parent(s) was notified 1. No 2. Yes → End ZVTD01CP V2(2)
- d. If not notified, reason: ZVTD01DR V2(300)

Comment ZVTCMMNT V2(800)