



**For Staff Use Only**

**Disposition at Triage:**

- 1 - Referred for Treatment
- 2 - Referred for Medical Evaluation
- 3 - Treatment Declined
- 4 - Other

**Disposition at Medical Evaluation:**

- 1 - Referred for Treatment
- 2 - Referred for Medical Care
- 3 - Treatment deferred due to Medical Contraindication
- 4 - Other

**(This Medical section must be blank or fully completed including the Date Med Administered field at bottom)**

**Medication 1**

Barcode #1

Place Medication  
Barcode#1 Here

**Area Inoculated:**

- 1-Left Arm    2-Right Arm    3-Oral    4-Left Thigh    5-Right Thigh
- 6-Nasal    7-Left Buttock    8-Right Buttock    9-Left Deltoid    10-Right Deltoid

**Person Providing Treatment**

Last 4 Digits of  
SSN or VID

Signature

Signature

**(This Medical section must be blank or fully completed including the Date Med Administered field at bottom)**

**Medication 2**

Barcode #2

Place Medication  
Barcode#2 Here

**Area Inoculated:**

- 1-Left Arm    2-Right Arm    3-Oral    4-Left Thigh    5-Right Thigh
- 6-Nasal    7-Left Buttock    8-Right Buttock    9-Left Deltoid    10-Right Deltoid

**Person Providing Treatment**

Last 4 Digits of  
SSN or VID

Signature

Signature

**(This Medical section must be blank or fully completed including the Date Med Administered field at bottom)**

**Medication 3**

Barcode #3

Place Medication  
Barcode#3 Here

**Area Inoculated:**

- 1-Left Arm    2-Right Arm    3-Oral    4-Left Thigh    5-Right Thigh
- 6-Nasal    7-Left Buttock    8-Right Buttock    9-Left Deltoid    10-Right Deltoid

**Person Providing Treatment**

Last 4 Digits of  
SSN or VID

Signature

Signature

**(This Medical section must be blank or fully completed including the Date Med Administered field at bottom)**

**Medication 4 (Must be blank for fully completed)**

Barcode #4

Place Medication  
Barcode#4 Here

**Area Inoculated:**

- 1-Left Arm    2-Right Arm    3-Oral    4-Left Thigh    5-Right Thigh
- 6-Nasal    7-Left Buttock    8-Right Buttock    9-Left Deltoid    10-Right Deltoid

**Person Providing Treatment**

Last 4 Digits of  
SSN or VID

Signature

Signature

**\* Date Medication Administered (MM/DD/YYYY)**

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