

Patient's Name _____

Patient's Date of Birth ____/____/____

- Patient identifier information is not transmitted to CDC -

**ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs)
INVASIVE PNEUMOCOCCAL DISEASE IN CHILDREN**



Form Approved
OMB No. 0920-XXXX (for CDC)
Exp. Date xx/xx/20xx

StateID: _____ Date of positive culture ____/____/____ Date form completed ____/____/____

—VACCINE HISTORY—

Child has never received vaccines

Vaccination history unknown

VACCINES	Dose #	Dates of immunizations	Manufacturer	Vaccine name	Lot #
Pneumococcal conjugate vaccine	1				
	2				
	3				
	4				
	5				
	6				
Pneumococcal polysaccharide vaccine	1				
	2				
Diphtheria/Tetanus/ Pertussis (DTP or DTaP)	1				
	2				
	3				
	4				
	5				
Haemophilus influenzae type B (Hib)	1				
	2				
	3				
	4				
Influenza vaccine	1				
	2				
	3				

When recording pneumococcal conjugate vaccine information, please differentiate between Prevnar® (PCV7) and Prevnar13® (PCV13)

For combination vaccines (e.g. Trihibit, Tetramune, ActHIB/DTwP) enter information for each vaccine component

Person completing the form (please print):

Name _____ Title _____

Please return form to: _____

Phone: () _____

Fax: () _____

Phone: () _____

Fax: () _____

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, CDC/ATSDR Reports Clearance Office, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-XXXX). Do not send the completed form to this address.