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 (aged ≥2 months to <5 years)

OMB No. 0920-0978

StateID: _____ **Date of positive culture** ___/___/___ **Date form completed** ___/___/___

☐ Child has never received vaccines ☐ Vaccination history unknown

VACCINES	Dose #	Dates of immunizations	Manufacturer	Vaccine name	Lot #
Pneumococcal conjugate vaccine **Prevnar13® (PCV13)**	1				
	Dose #1 source: | Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other ☐				
	2				
	Dose #2 source: | Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other ☐				
	3				
	Dose #3 source: | Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other ☐				
	4				
	Dose #4 source: | Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other ☐				
	5				
	Dose #5 source: | Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other ☐				
	6				
	Dose #6 source: | Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other ☐				
Pneumococcal polysaccharide vaccine **Pnuemovax®23 (PPSV23)**	1				
	Dose #1 source: | Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other ☐				
	2				
	Dose #2 source: | Medical Chart ☐ Registry ☐ Primary Care Provider ☐ Other ☐				
Diphtheria/Tetanus/ Pertussis (DTP or DTaP)	1				
	2				
	3				
	4				
	5				
Haemophilus influenzae type B (Hib)	1				
	2				
	3				
	4				

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

Health Care Provider Information

Was health care provider information available from the following sources?

Medical Chart: ☐ Yes ☐ No ☐ Did Not Check

Vaccine Registry: ☐ Yes ☐ No ☐ Did Not Check

Parent/Guardian: ☐ Yes ☐ No ☐ Did Not Check ☐ Refused

If yes to any sources,
How many providers were contacted? ___

Person completing the form (please print):

Name_____ Title _____ Phone: ( )_____ Fax: ( )_____

Please return form to: _____ Phone: ( )_____ Fax: ( )_____