

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)**



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 <b>Prevnar13® (PCV13)</b>	1					
	Dose #1 source:		Medical Chart <input type="checkbox"/>	Registry <input type="checkbox"/>	Primary Care Provider <input type="checkbox"/>	Other <input type="checkbox"/>
	2					
	Dose #2 source:		Medical Chart <input type="checkbox"/>	Registry <input type="checkbox"/>	Primary Care Provider <input type="checkbox"/>	Other <input type="checkbox"/>
	3					
	Dose #3 source:		Medical Chart <input type="checkbox"/>	Registry <input type="checkbox"/>	Primary Care Provider <input type="checkbox"/>	Other <input type="checkbox"/>
	4					
	Dose #4 source:		Medical Chart <input type="checkbox"/>	Registry <input type="checkbox"/>	Primary Care Provider <input type="checkbox"/>	Other <input type="checkbox"/>
	5					
	Dose #5 source:		Medical Chart <input type="checkbox"/>	Registry <input type="checkbox"/>	Primary Care Provider <input type="checkbox"/>	Other <input type="checkbox"/>
	6					
	Dose #6 source:		Medical Chart <input type="checkbox"/>	Registry <input type="checkbox"/>	Primary Care Provider <input type="checkbox"/>	Other <input type="checkbox"/>
Pneumococcal polysaccharide vaccine <b>Pnuemovax®23 (PPSV23)</b>	1					
	Dose #1 source:		Medical Chart <input type="checkbox"/>	Registry <input type="checkbox"/>	Primary Care Provider <input type="checkbox"/>	Other <input type="checkbox"/>
	2					
	Dose #2 source:		Medical Chart <input type="checkbox"/>	Registry <input type="checkbox"/>	Primary Care Provider <input type="checkbox"/>	Other <input type="checkbox"/>
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: ( ) \_\_\_\_\_

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 information, including suggestions for reducing this burden to CDC, CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA(0920-0978). Do not send the completed form to this address.