



CDC • National Center for Immunization and Respiratory Diseases

Haemophilus influenzae type b Vaccine and Extended Information Worksheet



This worksheet should be completed for all cases of Hib in children <15 years who had received a primary Hib vaccine series.

STATE ID:

State: _____

CDC ID:

1. Immunization dates and vaccine type from all sources (shot card, health care providers):

	Dates of Immunizations*				
	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DT, DTP, DTaP (alone, if combination check Hib box)	____/____/____ <input type="checkbox"/> DT <input type="checkbox"/> DTP <input type="checkbox"/> DTaP	____/____/____ <input type="checkbox"/> DT <input type="checkbox"/> DTP <input type="checkbox"/> DTaP	____/____/____ <input type="checkbox"/> DT <input type="checkbox"/> DTP <input type="checkbox"/> DTaP	____/____/____ <input type="checkbox"/> DT <input type="checkbox"/> DTP <input type="checkbox"/> DTaP	____/____/____ <input type="checkbox"/> DT <input type="checkbox"/> DTP <input type="checkbox"/> DTaP
Hib *See codes below	____/____/____ Vaccine Type* ____ Lot# _____	____/____/____ Vaccine Type* ____ Lot# _____	____/____/____ Vaccine Type* ____ Lot# _____	____/____/____ Vaccine Type* ____ Lot# _____	
Hepatitis B (alone if combination check Hib box)	____/____/____ <input type="checkbox"/> Administered at birth				
Polio	____/____/____ <input type="checkbox"/> OPV <input type="checkbox"/> IPV	____/____/____ <input type="checkbox"/> OPV <input type="checkbox"/> IPV	____/____/____ <input type="checkbox"/> OPV <input type="checkbox"/> IPV	____/____/____ <input type="checkbox"/> OPV <input type="checkbox"/> IPV	
MMR	____/____/____	____/____/____	____/____/____		
Varicella	____/____/____	____/____/____			

*Hib vaccine types (trade name-company)

- | | |
|---|--|
| 1. HbOC (HibTITER® Wyeth)
2. HbOC-DTP (Terramune® Wyeth)
3. PRP-T (OmniHib® GlaxoSmithKline)
4. PRP-T (ActHib® sanofi pasteur/Connaught/Merieux)
5. PRP-T-DTaP (TriHibit® sanofi pasteur/Connaught/Merieux) | 6. PRP-D (ProHIBit® Connaught) [no longer available]
7. PRP-OMP (PedvaxHIB® Merck)
8. PRP-OMP-HepB (COMVAX® Merck)
9. PRP-T—DTaP-IPV (Pentacel sanofi pasteur)
10. Unknown
11. Other (specify): _____ |
|---|--|

2. Birthweight: _____ lbs. _____ oz. OR _____ Grams

Household Information

3. What type of Medical insurance does the family have

- Private insurance such as through an employer or Blue Cross
- No insurance or self pay
- Medicaid
- Other (specify): _____
- Unknown

4. Country of Child's Birth: _____

5. Number of children aged <18 years who stay at same address at least 2 nights a week (including case-patient): _____

6. Number of people who stay at same address at least 2 nights a week (including case-patient): _____

7. Is there known previous contact with a person with Hib disease within the preceding 2 months? Yes No

If Yes, specify type of contact: _____

8. Significant past medical History If none check here If unknown check here

[check all that apply]

- | | |
|--|--|
| <input type="checkbox"/> Preterm birth(<37 weeks), Specify weeks _____ | <input type="checkbox"/> Ventricular hardware (VP shunt, etc.) |
| <input type="checkbox"/> Immunosuppression and/or HIV, specify _____ | <input type="checkbox"/> Other, specify _____ |
| <input type="checkbox"/> Cochlear implant | |

