CHRONOLOGICAL RECORD OF MEDICAL CARE

Smallpox Vaccination Clinical/Sick-call Follow up Note

1. Today's Date (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

2. Day 0 = Smallpox Vaccination Date ☐☐/☐☐/☐☐☐☐

2b. Days post vax ☐☐

3. Vital Signs Temp ☐☐☐.☐ Pulse ☐☐☐ Resp ☐☐ BP ☐☐☐/☐☐☐

4. Chief Compliant (Default = routine check)

5. Was there a bandage on the vaccination site? ○ Yes ○ No

5a. IF YES: How many days did patient use a bandage? ☐☐

5b. Did patient see the vaccination site every day or two? ○ Yes ○ No

6a. Vaccination site appearance today (Check all that apply)

- ☐ local redness
- ☐ bump
- ☐ reddish blister
- ☐ whitish blister
- ☐ scab or crust
- ☐ local itching
- ☐ local rash
- ☐ nothing

6a. Vaccination site appearance today (Check all that apply)

- ☐ local redness
- ☐ bump
- ☐ reddish blister
- ☐ whitish blister
- ☐ scab pr crust
- ☐ local itching
- ☐ local rash
- ☐ nothing seen
- ☐ patient did not remember/observe

7. Check anything else experienced after the smallpox vaccination (Check all that apply)

- ☐ headache
- ☐ body rash
- ☐ itchy all over
- ☐ eye infection
- ☐ fever (temp in box)
- ☐ muscle aches
- ☐ feeling lousy
- ☐ swollen lymph nodes
- ☐ bandage reaction
- ☐ chest pain
- ☐ shortness of breath
- ☐ other (describe in box)

8. Any problems following vaccination? (Check all they apply)

- ☐ Restricted activity — How many days? ☐☐
- ☐ Limited duty — How many days? ☐☐
- ☐ Missed work — How many days? ☐☐
- ☐ Took medication (list in box) — How many days? ☐☐
- ☐ Visited clinic or emergency room
- ☐ Hospitalized
- ☐ Other (described in box)

9. Vaccination Site measures (if indicated)

Erythema length (mm) ☐☐☐ X width ☐☐☐

Vesicle length (mm) ☐☐☐ X width ☐☐☐

Note any other reactions, problems or medications following vaccination:

10. Does the patient believe anyone might have become ill as a result of the vaccination? ○ Yes ○ No ○ Unsure

If YES or UNSURE describe in box (or on continuation page)

11. Assessment and Plan (check all that apply:

- ☐ Fully Immunized ("major reaction, "take")
- ☐ Equivocal response
- ☐ Referred to Vaccine Healthcare Centers
- ☐ Re-vaccination indicated
- ☐ Follow-up for events described
- ☐ Medication prescribed (list)
- ☐ No further follow up planned
- ☐ Consultation Allergy/Immunology/Dermatology/Cardiology/other_____)
- ☐ Other action (describe in box) Report to VAERS if warranted.

11a. Other assessment/plan related to evaluation

12. Duty limitations

- ☐ Full duty
- ☐ No direct patient care
- ☐ Quarters for ___ days
- ☐ Urgent/Emergent referral
- ☐ Routine referral

Provider Signature and Printed Name/Stamp

Patient's identification (May use mechanical imprint)

Last Name

First Name MI

Social Security Number

RECORDS MAINTAINED AT:
RANK/GRADE
SEX
DATE OF BIRTH
SPONSOR NAME
(or Sponsor SSN)
RELATIONSHIP TO SPONSOR
(Or FMP)
ORGANIZATION
STATUS
DEPT/SVC