CHRONOLOGICAL RECORD OF MEDICAL CARE

Smallpox Vaccination Continuation Note

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

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Additional Notes on Problems, Issues or Concerns of Patient or Provider related to Vaccine Assessment or Follow-up. Subjective section may be filled out by either patient/vaccine or provider. Objective findings, Assessment and Plan should be completed by a provider.

Subjective: History of issues related to vaccination assessment or follow-up

Objective: Relevant exam, test or laboratory findings

Assessment: Integrated summary

Plan

Provider Signature and Printed Name/Stamp:

Last Name

First Name MI

Social Security Number

Patient's identification (May use mechanical imprint)

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