Photo

U.S. Department of State

VACCINATION DOCUMENTATION WORKSHEET

To Be Completed by Panel Physician Only
For US Vaccination Requirements

OMB No. 1405-0113
EXPIRATION DATE: 09/30/2017
ESTIMATED BURDEN: 30 minutes
(See Page 2 of 2)

GIVE COPY TO APPLICANT

Name *(Last, First, MI)*	Birth Date *(mm-dd-yyyy)*	Exam Date *(mm-dd-yyyy)*	Blanket Waiver(s) To Be Requested If Vaccination Not Medically Appropriate.
Passport Number	Alien *(Case)* Number		Indicate reason below. Mark all that apply (see legend):

1. Immunization Record
Vaccine History Transferred From a Written Record
List Chronologically from Left to Right. Provide date as mm-dd-yyyy

Vaccine	Date	Date	Date	Date	Vaccine Given By Panel Site	For Designated Refugees Only: Additional Vaccine Given by IOM*		Test for Immunity	A, B, C, D, F, H
Diphtheria, tetanus, pertussis									
☐ DT, DTP, DTaP									
☐ Td									
☐ Tdap									
Polio									
☐ OPV									
☐ IPV									
Measles, mumps, rubella									
☐ MMR									
☐ Measles									
☐ Mumps									
☐ Rubella									
Rotavirus									
☐ RotaTeq (RV5)									
☐ Rotarix (RV1)									
Hib									
Hepatitis A									
Hepatitis B									
Meningococcal									
☐ MCV4									
☐ Other MCV conjugate									
Varicella									
☐ Vaccine									
☐ Varicella History									
Pneumococcal									
☐ PCV 7									
☐ PCV 10									
☐ PCV 13									
☐ PPSV 23									
Influenza									
Other									

2. Summary for Immigrant Visa Applicants

☐ US vaccination requirements COMPLETE
(Requesting a Blanket Waiver)

US vaccination requirements NOT Complete:

☐ Requesting Individual Waiver based on religious or moral convictions

☐ Requesting Adoptee Exemption

☐ Applicant refuses vaccinations

3. Panel Physician Name (printed) _____

I attest I performed this examination and have an agreement with the Department of State or supervised completion of this form. I am the same Panel Physician that signs the DS 2054.

Panel Physician signature	Date *(mm-dd-yyyy)*

*** Only for designated refugees in special IOM vaccination program**

Blanket waiver legend: **A** Not age appropriate **B** Insufficient time interval to complete series **C** Contraindicated **D** Not routinely available **F** Not flu season **H** Known chronic hepatitis B virus infection

DS-3025
09-2014

Please complete Page 2

4. Contraindication to vaccination

If a vaccination was contraindicated, mark which contraindication were present *(mark all that apply)*

- ☐ Pregnant
- ☐ Immune compromised
- ☐ History of severe allergic reaction to vaccine or vaccine component
- ☐ Other severe reaction to vaccine
- ☐ Current moderate to severe illness
- ☐ Other, specify: _____

5. Remarks

6. Panel Physician Initials	**Date *(mm-dd-yyyy)***

PAPERWORK REDUCTION ACT STATEMENT

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: PRA_BurdenComments@state.gov

CONFIDENTIALITY STATEMENT

AUTHORITIES The information asked for on this form is requested pursuant to Section 212(a) and 221(d) and as required by Section 222 of the Immigration and Nationality Act. Section 222(f) provides that the records of the Department of State and of diplomatic and consular offices of the United States pertaining to the issuance and refusal of visas or permits to enter the United States shall be considered confidential and shall be used only for the formulation, amendment, administration, or enforcement of the immigration, nationality, and other laws of the United States. Certified copies of such records may, in the discretion of the Secretary of State, be made available to a court provided the court certifies that the information contained in such records is needed in a case pending before the court.

PURPOSE The U.S. Department of State uses the facts you provide on this form primarily to determine your classification and eligibility for a U.S. immigrant visa. Individuals who fail to submit this form or who do not provide all the requested information may be denied a U.S. immigrant visa. Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.

ROUTINE USES If you are issued an immigrant visa and are subsequently admitted to the United States as an immigrant, the Department of Homeland Security will use the information on this form to issue you a Permanent Resident Card, and, if you so indicate, the Social Security Administration will use the information to issue a social security number. The information provided may also be released to federal agencies for law enforcement, counterterrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies who may need the information to administer or enforce U.S. laws. More information on the Routine Uses for this collection can be found in the System of Records Notice State-24, Medical Records.