# Texas Department of State Health Services Monthly Biological Report

Agency ______________________ Month / Year of Report ____________ PIN ____________

Address ______________________ Name of Person Completing This Report ____________

City ______________ Zip ________ Telephone Number With Area Code ____________

See reverse for instructions

| Vaccine | A. Doses on Hand at Beginning of Month *Beginning inventory* | B. Doses Received During Month *Add to inventory* | C. Usable Doses Returned to Your Inventory *Add to inventory* | D. A+B+C= *Subtotal* | E. Doses Administered During Month *Subtract total from inventory* | | | F. Doses Sent Back to Vaccine Distributor. *Subtract from inventory* | G. Doses Issued Out of Your Inventory to Other Providers *Subtract from inventory* | H. Doses on Hand at End of Month *Ending inventory* | I. Net Doses Lost or Gained: Enter (-) or (+) Figure |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | <1-18 | 19+ | Total | | | | |
| DT | | | | | | | | | | | |
| DTaP | | | | | | | | | | | |
| DTaP-HEP B-IPV | | | | | | | | | | | |
| DTaP-IPV/Hib | | | | | | | | | | | |
| DTaP-IPV | | | | | | | | | | | |
| HEP A | | | | | | | | | | | |
| HEP B | | | | | | | | | | | |
| Hib | | | | | | | | | | | |
| HIB-HEP B | | | | | | | | | | | |
| HPV | | | | | | | | | | | |
| INFLUENZA 0.25 mL | | | | | | | | | | | |
| INFLUENZA 0.5 mL | | | | | | | | | | | |
| INFLUENZA-Intranasal | | | | | | | | | | | |
| IPV | | | | | | | | | | | |
| MCV 4 | | | | | | | | | | | |
| MMR | | | | | | | | | | | |
| MMRV | | | | | | | | | | | |
| PCV 7 | | | | | | | | | | | |
| PNEUMOCOCCAL | | | | | | | | | | | |
| ROTAVIRUS | | | | | | | | | | | |
| Td | | | | | | | | | | | |
| Tdap | | | | | | | | | | | |
| VARICELLA | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

**This is to certify that this report is a true accounting of the above biologicals received from the Texas Department of State Health Services that were administered during the reported time period. No one was refused immunizations for failure to pay an administrative fee or failure to make a donation to the provider.**

**Explanation of all doses returned (F column) and doses gained and lost (I column):**

**Signature of local health authority or person responsible for vaccine administration** ______ Date ______ Phone ( ) ______

Form C-33 Rev. 10/2008