

Ulster County Department of Health  
239 Golden Hill Lane  
Kingston, New York 12401  
Phone: (845) 340-3010 Fax: (845) 340-3045  
After Normal Business Hours: (845) 334-2145 *answering service*

**AUTHORIZATION FOR RABIES POST EXPOSURE PROPHYLAXIS (RPEP)**

To be completed by UCDOH:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: Male Female (please circle)

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Description of Injury (body site): \_\_\_\_\_

Authorization for RPEP: \_\_\_\_\_ Date: \_\_\_\_\_  
(UCDOH Representative Signature)

Date Faxed to ER: \_\_\_\_\_ Initials: \_\_\_\_\_

To be completed by ER (fax to, 845-334-2805):

**Health Alliance ER Vaccination Report**

Treatment: \_\_\_\_\_

1. HRIG Administration: No: \_\_\_\_\_ Yes: \_\_\_\_\_ (if yes, complete)

Date: \_\_\_\_\_ Dose: \_\_\_\_\_ Site: \_\_\_\_\_ Lot #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

*(Over)*

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
DOB

**2. Human Rabies Vaccine (4 doses):**

	Dose	Site	Lot #	Expiration	Signature
Day 0:	_____ (Date)	_____	_____	_____	_____
Day 3	_____ (Date)	_____	_____	_____	_____
Day 7	_____ (Date)	_____	_____	_____	_____
Day 14	_____ (Date)	_____	_____	_____	_____

Immuno-suppressed patients only: No: \_\_\_\_\_ Yes: \_\_\_\_\_ (if yes, need 5<sup>th</sup> dose)

	Dose	Site	Lot #	Expiration	Signature
Day 28	_____ (Date)	_____	_____	_____	_____

**3. Booster (previously vaccinated 2 doses):**

	Dose	Site	Lot #	Expiration	Signature
Day 0:	_____ (Date)	_____	_____	_____	_____
Day 3	_____ (Date)	_____	_____	_____	_____

\* Rabies Immune Globulin is not needed

Vaccination Information Statement (VIS) given: \_\_\_\_\_  
(Date)

Please fax/send form after each vaccine administered or once determination of series is no longer required to:

UCDOH, Environmental Health Services, 239 Golden Hill Lane, Kingston, NY 12401  
Fax: (845) 340-3045