

Vaccine Administration Record

Patient Name: _____

Date of Birth: ____/____/____

Parent/Guardian Signature: _____

(Optional)

Provider/Clinic Name & Address:

VACCINE* (Please Circle Appropriate Vaccine)	Date Administered	Vaccine Manufacturer	Vaccine Lot Number	Name and Title of Vaccine Administrator	Date Vaccine Information Statements Given	Publication Date of Vaccine Information Statements
DTaP 1 or DT 1						05/17/07
DTaP 2 or DT 2						05/17/07
DTaP 3 or DT 3						05/17/07
DTaP 4 or DT 4						05/17/07
DTaP 5 or DT 5						05/17/07
IPV 1						11/08/11
IPV 2						11/08/11
IPV 3						11/08/11
IPV 4						11/08/11
Hib 1						04/02/15
Hib 2						04/02/15
Hib 3						04/02/15
Hib 4						04/02/15
PCV 1						02/27/13
PCV 2						02/27/13
PCV 3						02/27/13
PCV 4						02/27/13
MMR 1						04/20/12
MMR 2						04/20/12
Varicella 1						03/13/08
Varicella 2						03/13/08
History of Varicella Disease Date (month/year):						
Hepatitis B 1						02/02/12
Hepatitis B 2						02/02/12
Hepatitis B 3						02/02/12
Influenza 1						Annual
Influenza 2						Annual
Tdap						02/24/15
Td						02/24/15
MCV						10/14/11
MCV						10/14/11
Meningococcal B						08/14/15
Hepatitis A 1						10/25/11
Hepatitis A 2						10/25/11
Rotavirus 1						04/15/15
Rotavirus 2						04/15/15
Rotavirus 3						04/15/15
HPV9 1						04/15/15
HPV9 2						04/15/15
HPV9 3						04/15/15

* - When combination vaccines are given, enter the vaccine information in each separate vaccine row.