ADOLESCENT & ADULT IMMUNIZATION RECORD

CLINIC*:*

Name:_____

Date of birth:___/___/_____ Record #_____

Allergies:_____ Reactions:_____

History of Chickenpox? YES or NO If yes, date if known:_____

Vaccine	Date Admin			Age at the time	VIS Form Given			Manuf Abbr*	Lot Number	Dose	Admin Site**	Route	Provider Initials*** or Outside Provider Name
	Mo	Day	Yr		Type	Mo	Yr						
Td					Td					0.5cc		IM	
Td					Td					0.5cc		IM	
Td					Td					0.5cc		IM	
Td					Td					0.5cc		IM	
Tdap					Tdap					0.5cc		IM	
Hep B					Hep B							IM	
Hep B					Hep B							IM	
Hep B					Hep B							IM	
Hep B (booster if needed)					Hep B							IM	
MMR Rubella Rubeola					MMR					0.5cc		SQ	
MMR Rubella Rubeola					MMR					0.5cc		SQ	
Varicella					Var					0.5cc		SQ	
Varicella					Var					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
PPV23					PPV					0.5cc		IM	
PPV23					PPV					0.5cc		IM	
Hepatitis A					Hep A							IM	
Hepatitis A					Hep A							IM	
HPV					HPV					0.5cc		IM	
HPV					HPV					0.5cc		IM	
HPV					HPV					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
MCV4					Mening							IM	
MPSV4					Mening							SQ	

*** Manufacturers: M = Merck; S = Sanofi Pasteur; W = Wyeth; G = GlaxoSmithKline**

****Sites: LT = Left Thigh, RT = Right Thigh, LA = Left Arm, RA = Right Arm, LD = Left Deltoid, RD = Right Deltoid**

*****VIS Language given, if not English: _____**

***Provider Information

First Name	MI	Last Name	Title	Full Signature	Initials

Tuberculin Test

Date Admin			Test Type		Provider*** placing the test	Provider*** reading the test	Results	Notes
Mo	Day	Yr	PPD	Tine				

Titer Test Results for Non Susceptibility (IgM)

Date			Disease	✔ Results		Notes
Mo	Day	Yr		Neg	Pos	

Vaccine	Date Admin			Age at the time	VIS Form Given			Manuf Abbr*	Lot Number	Dose	Admin Site**	Route	Provider Initials*** or Outside Provider
	Mo	Day	Yr		Type	Mo	Yr						