

Vaccine Administration Record - Page 2

Last Name:	First Name:	Middle Name:	Patient ID:
Date of Birth:	Age:	Contraindication:	

DO NOT GO BELOW THIS LINE - FOR CLINIC USE ONLY	
Clinic:	Date Vaccinated: Date Information Statement Provided to Parent/Guardian/Patient:

Vaccine	Dose	Manufacturer & Lot #	Route/Site	Date of VIS
DT Td DTaP Tdap				
IPV				
MMR				
Hib				
Hep B				
Varicella				
PCV-7				
MCV4				

Influenza				
Hep A				

* DTaP or DT should be given to patients under 7 years old. Td should be given to patients 7 years old or older.
 ** If an adolescent has already begun the routine 3 dose Hep-B schedule, they should not be changed to the 2 dose schedule.

X _____
 Signature and Title of Vaccine Administrator