

Vaccine Administration Record

Patient Name: _____
Birthdate: ___/___/___
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						07/30/01
DTaP 2 or DT 2						07/30/01
DTaP 3 or DT 3						07/30/01
DTaP 4 or DT 4						07/30/01
DTaP 5 or DT 5						07/30/01
IPV 1						01/01/00
IPV2						01/01/00
IPV3						01/01/00
IPV4						01/01/00
Hib 1						12/16/98
Hib 2						12/16/98
Hib 3						12/16/98
Hib 4						12/16/98
PCV 7 1						09/30/02
PCV 7 2						09/30/02
PCV 7 3						09/30/02
PCV 7 4						09/30/02
MMR1						01/15/03
MMR2						01/15/03
Varicella 1						12/16/98
Varicella 2						12/16/98
History of Varicella Disease Date (Month/Yr.):						
Hepatitis B 1						07/11/01
Hepatitis B 2						07/11/01
Hepatitis B 3						07/11/01
Influenza 1						
Influenza 2						
Tdap						05/31/06
Td						06/10/94
Td						06/10/94
MCV4						10/07/05
Hepatitis A 1						03/21/06
Hepatitis A 2						03/21/06
Rotavirus 1:						04/12/06
Rotavirus 2:						04/12/06
Rotavirus 3:						04/12/06
Other:						
Other:						
Other:						

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