Immunization Record

LAST NAME	FIRST NAME	M.I.

BIRTHDATE (mm/dd/yy)

INSTRUCTIONS

Record the Type (HepB) and the Date (m/d/yy) for each vaccination given. For combination vaccines (like Hib-HepB), complete a row under each separate antigen in the combination. Take a copy of your immunization record with you when you visit a healthcare professional. Have them assist you in completing the form. For information about the vaccines and recommended immunization schedules, see the Center for Disease Control and Prevention website at http://www.cdc.gov/vaccines. Once complete sign the bottom of the form.

Vaccine	Type	Date Given (m/d/yy)	Administered By (clinic, doctor, etc)	Next Dose Date
Hepatitis B (HepB, Hib-HepB, HepA-HepB, DTaP-HepB-IPV)				
Diptheria, Tetanus, Pertussis (DTaP, DTP, DT, Td, Tdap, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, DTaP/Hib) boosters				
***Haemophilus influenzae* type b** (Hib, Hib-HepB, DTaP-IPV/Hib, DTaP/Hib)				
Pneumococcal (PCV7, PCV13, PPSV23)				
Polio (IPV, OPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)				
Rotavirus (RV1, RV5, RV [unknown])				
Measles, Mumps, & Rubella (MMR, MMRV)				
Varicella (chickenpox) (VAR, MMRV)				

Vaccine	Type	Date Given (m/d/yy)	Administered By (clinic, doctor, etc)	Next Dose Date
Hepatitis A (HepA, HepA-HepB)				
Meningococcal (MCV4, MPSV4)				
Human papillomavirus (HPV4, HPV2)				
Zoster (shingles)				
Influenza (yearly) (TIV, LAIV)				
Other				

Signature: _____