Vaccine Administration Record

PATIENT NAME: ____________________
DATE OF BIRTH: ____________________
PROVIDER NAME: ____________________
ADDRESS: ____________________
CITY, STATE, ZIP: ____________________

(Provider's stamp)

***SITE ROUTE LEGEND**
RA= *Right Arm*
LA= *Left Arm*
RT= *Right Thigh*
LT= *Left Thigh*
PO= *Oral*
IM= *Intramuscular*
SQ= *Subcutaneous*

CIRCLE VACCINE	DATE GIVEN M/D/Y	SITE/ ROUTE	VACCINE		VACCINE INFORMATION STATEMENT (VIS)		VACCINATOR (signature or initials & title)	PARENT/ GUARDIAN/ SIGNATURE/ DESIGNEE	VFC ✓ YES
			LOT#	MFR.	DATE ON VIS	DATE GIVEN			
DTaP DTaP/Hepb/IPV DT									
DTaP DTaP/Hepb/IPV DT									
DTaP DTaP/Hepb/IPV DT									
DTaP DT									
DTaP DTaP/IPV DT									
Hep A									
Hep A									
Hep B									
Hep B									
Hep B									
Hib HepB/Hib DTaP/Hib/IPV									
Hib HepB/Hib DTaP/Hib/IPV									
Hib HepB/Hib DTaP/Hib/IPV									
Hib DTaP/Hib/IPV									
HPV									
HPV									
HPV									
Influenza									
Influenza									
IPV									
IPV									
IPV									
IPV									
Meningo Conj (MCV4)									
Meningo Conj (MCV4)									
MMR MMRV									
MMR MMRV									
PCV 13									
PCV 13									
PCV 13									
PCV 13									
Pneumococcal Polysaccharide									
Rotavirus									
Rotavirus									
Rotavirus									
Td									
Td Tdap									
Varicella									
Varicella									
Other:									