Immunization Record

Patient Name _____ Birth Date ____ /____ /____ Chart No._____

"I have been given a copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Material(s) and have read, or have had explained to me, information about the vaccines listed below. All questions have been answered to my satisfaction. I believe that I understand the benefits and risks of the vaccines recommended and hereby give permission for the vaccines listed below to be given to me or the the patient listed above, for whom I am authorized to give this permission."

Practice Name/Address

Vaccine *Check Vaccine Given*	Date m/d/y	Age	Vaccine Co. & (F, S, P)*	Vaccine Lot# & Exp. Date	Vaccine Info. Pub. Date**	Injec. Site	Signature of Vaccine Provider	Signature of Parent or Guardian
☐ DTaP-IPV-Hib or ☐ DTaP, ☐ DT ☐ DTaP-IPV-HepB								
☐ DTaP-IPV-Hib or ☐ DTaP, ☐ DT ☐ DTaP-IPV-HepB								
☐ DTaP-IPV-Hib or ☐ DTaP, ☐ DT ☐ DTaP-IPV-HepB								
☐ DTaP-IPV-Hib or ☐ DTaP, ☐ DT								
☐ DTaP, ☐ DT								
☐ Tdap, ☐ Td								
☐ Td								
☐ Hib								
☐ Hib-HepB ☐ Hib-HepB or ☐ Hib-HepB	☐ Hib							
	☐ Hib							
	☐ Hib							
☐ HepB								
☐ HepB								
☐ HepB								
☐ IPV								
☐ IPV								
☐ IPV								
☐ IPV								
☐ MMR-Varicella or ☐ MMR								
☐ Varicella								
☐ MMR-Varicella or ☐ MMR								
☐ Varicella								
☐ PCV7								
☐ PCV7								
☐ PCV7								
☐ PCV7								
☐ Rotavirus								
☐ Rotavirus								
☐ Rotavirus								
☐ Meningococcal								

☐ **Tuberculin, Hep A, HPV, Influenza, OPV and additional vaccines on back.**

* Vaccine funding source: F=Federal, S=State, P=Private **Vaccine information publication date if required by state law