

Immunization Record

Patient's Name: _____ Reference Record #: _____

Tel: (home) _____ (Mobile) _____ Date of Birth: _____

Gender: Male Female

Insurance Details: _____

Name of the Vaccine	Dose 1 (MM/DD/YY)	Dose 2 (MM/DD/YY)	Dose 3 (MM/DD/YY)	Dose 4 (MM/DD/YY)	Dose 5 (MM/DD/YY)	Signature of Patient or Guardian
Required Vaccinations for School						
Diphtheria and Tetanus (DT)	/ /	/ /	/ /	/ /	/ /	
Diphtheria, Tetanus, Pertussis (DTap, DTP) (6 and -)	/ /	/ /	/ /	/ /	/ /	
Haemophilus Influenzae b (Hib)	/ /	/ /	/ /	/ /	/ /	
Polio (OPV, IPV)	/ /	/ /	/ /	/ /		
Tetanus and Diphtheria (Tdap, Td) (7 and +)	/ /	/ /	/ /			
Measles, Mumps and Rubella (MMR) (1 and +)	/ /	/ /	/ /			
Hepatitis B (Hep B)	/ /	/ /	/ /			
Varicella (chicken pox) (1 and +)	/ /	/ /				
Recommended for School						
Human Papillomavirus (HPV)	/ /	/ /	/ /			
Hepatitis A (Hep A)	/ /	/ /				
Meningococcal (MCV) (MPSV)	/ /	/ /				

Notes/Comments: _____
