Vaccine Administration Record

PATIENT NAME _____
DATE OF BIRTH _____
PROVIDER NAME _____
ADDRESS _____
CITY, STATE ZIP _____

***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 MANUFACTURER	VACCINE LOT NUMBER	VIS DATE	MD/RN INITIALS	PARENT/ GUARDIAN/ SIGNATURE/ DESIGNEE	VFC ELIGIBILITY ✓ FOR YES
DTaP DTaP/Hib/IPV DT								
DTaP DTaP/Hib/IPV DT								
DTaP DTaP/Hib/IPV DT								
DTaP DT								
DTaP DTaP/IPV DT								
Hep A								
Hep A								
Hep B								
Hep B								
Hep B								
Hib DTaP/Hep B/IPV								
Hib HepB/Hib DTaP/Hep B/IPV								
Hib HepB/Hib DTaP/Hep B/IPV								
Hib HepB/Hib DTaP/Hep B/IPV								
HPV								
HPV								
HPV								
Influenza								
Influenza								
IPV								
IPV								
IPV								
IPV								
Meningococcal Conjugate (MCV4)								
MMR MMRV								
MMR MMRV								
PCV 7								
PCV 7								
PCV 7								
PCV 7								
Pneumococcal Polysaccharide								
Rotavirus								
Rotavirus								
Rotavirus								
Td								
Td Tdap								
Varicella								
Varicella								
Other:								