VACCINE ADMINISTRATION
PATIENT RECORD

Last Name:	First Name:	Middle Name:	Patient ID:
Date of Birth:	Age:	Contraindication:	
DO NOT WRITE BELOW THIS LINE - For Clinic Use Only			
Clinic:		Date Vaccinated: Date VIS Provided to Parent/Guardian/Patient:	

Vaccine	Dose	Manf. & Lot #	Route/Site	Date of VIS
DT Td DTaP Tdap				
IPV				
MMR				
HIB				
Hep B				
Varicella				
PCV-7				
MCV4				

X _____
Signature and Title of Vaccine Administrator