SAMPLE IMMUNIZATION RECORD

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PART I

Name ____ ____
First Name   Middle Name

____
Last Name

Address ____
Street   City   State   Zip

Date of Entry ____/________ (M Y)   Date of Birth ____/____/________ (M D Y)   School ID# ____________________________________

Status: Part-time _____   Full-time _____   Graduate _____   Undergraduate _____   Professional _____

PART II: TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

All information must be in English.

A. MMR (MEASLES, MUMPS, RUBELLA)

1. Dose 1 given at age 12 months or later . ... #1 ____/____/_______ (M D Y)
2. Dose 2 given at least 28 days after first dose . ... #2 ____/____/_______ (M D Y)

B. MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135)

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).

   a. Dose #1 ____/____/________ (M D Y)   b. Dose #2 ____/____/________ (M D Y)

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available).   Date ____/____/_______ (M D Y)

C. SEROGROUP B MENINGOCOCCAL

The vaccine series must be completed with the same vaccine.

1. MenB-RC (Bexsero)   __ routine   ____outbreak –related

   a. Dose #1 ____/____/________ (M D Y)   b. Dose #2 ____/____/________ (M D Y)

OR

2. MenB-FHbp (Trumenba)   __routine   ___outbreak-related

   a. Dose #1 ____/____/________ (M D Y)   b. Dose #2 ____/____/________ (M D Y)   c. Dose #3 ____/____/_______ (M D Y)

D. TETANUS, DIPHTHERIA, PERTUSSIS

1. Primary series completed?   Yes ___   No ___   Date of last dose in series: ____/____/_______ (M D Y)
2. Date of most recent booster dose: ____/____/_______ (M D Y)   Type of booster: Td _____   Tdap _____

E. INFLUENZA

Trivalent (IIV3) _____ Quadrivalent (IIV4) _____ Recombinant (RIV4) _____ Live attenuated influenza vaccine (LAIV) _____

Adjuvanted inactivated influenza (aIIV3) _____

Date of last dose: ____/____/_______ (M D Y)

F. HEPATITIS A

1. Immunization (hepatitis A)

a. Dose #1 ____/____/________ (M D Y)   b. Dose #2 ____/____/________ (M D Y)

2. Immunization (Combined hepatitis A and B vaccine)

a. Dose #1 ____/____/________ (M D Y)   b. Dose #2 ____/____/________ (M D Y)   c. Dose #3 ____/____/_______ (M D Y)

G. HEPATITIS B

Heplisav-B (2 dose series) is not interchangeable with other hepatitis B vaccines (3 dose series) but can substituted for dose #2 and #3.

1. Immunization (hepatitis B)

a. Dose #1 ____/____/________ (M D Y)
Adult formulation ___ Child formulation ____
HepB-CpG (Heplisav-B) ____

b. Dose #2 ____/____/________ (M D Y)
Adult formulation ____ Child formulation ____
HepB-CpG (Heplisav-B) ____

c. Dose #3 ____/____/________ (M D Y)
Adult formulation ____ Child formulation ____
HepB-CpG (Heplisav-B) ____

2. Immunization (Combined hepatitis A and B vaccine)

a. Dose #1 ____/____/________ (M D Y)   b. Dose #2 ____/____/________ (M D Y)   c. Dose #3 ____/____/________ (M D Y)

3. Hepatitis B surface antibody (recommended for individuals born in or whose mother was born in a hepatitis B endemic country and/or men who have sex with men; required for health science students).

Date ____/____/________   Result: Reactive ________   Non-reactive ________

H. HUMAN PAPILLOMAVIRUS VACCINE

Immunization (indicate which preparation, if known)   Quadrivalent (HPV4) _____   or   Bivalent (HPV2) _____   or 9-valent (HPV9) ____

a. Dose #1 ____/____/________ (M D Y)   b. Dose #2 ____/____/________ (M D Y)   c. Dose #3 ____/____/________ (M D Y)

I. VARICELLA

1. Immunization

a. Dose #1 . ... #1 ____/____/________ (M D Y)

b. Dose #2 given at least 12 weeks after first dose ages 1–12 years. .... #2 ____/____/________ (M D Y)
and at least 4 weeks after first dose if age 13 years or older.

2. History of Disease   Yes ___   No ___   or   Birth in U.S. before 1980   Yes ___   No ___

J. PNEUMOCOCCAL POLYSACCHARIDE VACCINE

PCV 13 _______   Date ____/____/_______ (M D Y)   PPSV 23 _______   Date ____/____/_______ (M D Y)

K. POLIO

1. OPV alone (oral Sabin three doses):   #1 ____/____/________ (M D Y)   #2 ____/____/________ (M D Y)   #3 ____/____/________ (M D Y)

2. IPV/OPV sequential: IPV #1 ____/____/________ (M D Y)   IPV #2 ____/____/________ (M D Y)   OPV #3 ____/____/________ (M D Y)   OPV #4 ____/____/________ (M D Y)

3. IPV alone (injected Salk four doses):   #1 ____/____/________ (M D Y)   #2 ____/____/________ (M D Y)   #3 ____/____/________ (M D Y)   #4 ____/____/________ (M D Y)

HEALTH CARE PROVIDER

Name ____   Signature ____

Address ____   Phone (__________)________________________________

END of SAMPLE FORM

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