Pediatric Vaccine Record

Clinic Name/Address

Patient Name: _____

Birth Date: _____

Vaccine	Date Given	Manufacturer	Lot Number	Site	Administered by	Parent/Guardian
DTaP #1						
DTaP #2						
DTaP #3						
DTaP #4						
DTaP #5						
Tdap						
Hib # 1						
Hib # 2						
Hib # 3						
Hib # 4						
IPV #1						
IPV #2						
IPV #3						
IPV #4						
MMR #1						
MMR #2						
HepB #1						
HepB #2						
HepB #3						
HepB #4						
Varicella #1						
Varicella #2						
PCV #1						
PCV #2						
PCV #3						
PCV #4						
HepA #1						
HepA #2						
MCV4 #1						
MCV4 #2						
Rotavirus #1						
Rotavirus #2						
Rotavirus #3						
HPV #1						
HPV #2						
HPV #3						
Influenza						
Influenza						
Influenza						
Influenza						

Site Given Legend	Initials	Practitioner Signature	Initials	Parent Signature*
RA = Right Arm				
LA = Left Arm				
RT = Right Thigh				
LT = Left Thigh				
O = Oral				
IN = Intranasal				

* I have read or have had explained to me information about the diseases and vaccines listed above. I have had a chance to ask questions and they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines cited, and ask that the vaccine(s) listed above be given to the person named above for whom I am authorized to make this request. My initials under Parent/Guardian signify my consent to the vaccination given on the corresponding date.

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