

# VACCINE ADMINISTRATION RECORD

Patient Name \_\_\_\_\_  
 Record # \_\_\_\_\_  
 Birthdate \_\_\_\_\_

Clinic Info  
 (Name/Address)

"I have read, or have had explained to me, information about the diseases and vaccines listed below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines cited, and ask that the vaccine(s) listed below be given to me or to the person named above (for whom I am authorized to make this request)."

Vaccine	Date Given (mm/dd/yy)	Vaccine Manufacturer	Vaccine Lot Number	Site Given	Initials of Vaccine Administrator	Signature of Parent or Guardian
DTP 1						
DTP 2						
DTP 3						
DTP/DTaP 4						
DTP/DTaP 5						
DT						
Td						
OPV/IPV 1						
OPV/IPV 2						
OPV/IPV 3						
OPV/IPV 4						
MMR 1						
MMR 2						
Hib 1						
Hib 2						
Hib 3						
Hib 4						
Hep B 1						
Hep B 2						
Hep B 3						

Signature of Vaccine Administrator \_\_\_\_\_  
 (use reverse side if more signatures are needed) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_