

ADOLESCENT & ADULT IMMUNIZATION RECORD

Clinic: _____

Name: Wanbing Yu

Date of Birth: 12/24/99 Record #: _____

Allergies: _____ Reactions: _____

History of Chickenpox? YES or NO If yes, date if known: _____

Vaccine	Date Admin			Age at the time	VIS Form Given			Manufacturer Abbr*	Dose	Admin Site**	Route	Provider Initials*** or Outside Provider Name
	Mo	Day	Yr		Type	Mo	Yr					
Td					Td				0.5cc		IM	
Td					Td				0.5cc		IM	
Td					Td				0.5cc		IM	
Td					Td				0.5cc		IM	
Tdap	4	28	20		Tdap	2	15		0.5cc	LD	IM	Am
Hep B					Hep B						IM	
Hep B					Hep B						IM	
Hep B					Hep B						IM	
Hep B (booster if needed)					Hep B						IM	
MMR Rubella Rubeola	4	28	20		MMR				0.5cc	LA	SQ	Am
MMR Rubella Rubeola					MMR				0.5cc		SQ	
Varicella					Var				0.5cc		SQ	
Varicella					Var				0.5cc		SQ	
IPV					Polio				0.5cc		SQ	
IPV					Polio				0.5cc		SQ	
IPV					Polio				0.5cc		SQ	
IPV					Polio				0.5cc		SQ	
PPV23					PPV				0.5cc		IM	
PPV23					PPV				0.5cc		IM	
Hepatitis A					Hep A						IM	
Hepatitis A					Hep A						IM	
HPV					HPV				0.5cc		IM	
HPV					HPV				0.5cc		IM	
HPV					HPV				0.5cc		IM	
Influenza					Flu				0.5cc		IM	
Influenza					Flu				0.5cc		IM	
Influenza					Flu				0.5cc		IM	
MCV4					Mening						IM	
MPSV4					Mening						SQ	

* Manufacturers: M= Merck; S= Sanofi Pasteur; W= Wyeth; G= GlaxoSmithKline

** Sites: LT = Left Thigh, RT = Right Thigh, LA = Left Arm, RA = Right Arm, LD = Left Deltoid, RD = Right Deltoid

*** VIS Language given, if not English: _____

First Name	MI	Last Name	Title	Full Signature	Initials
Amy Melodye	D M	Morris Harvey	RN CRNP	<i>[Handwritten Signature]</i> M. Harvey, CRNP	AM MH

[illegible][illegible][illegible]