

Vaccine Administration Record for Adults

Patient name Otis R. Allen

Birthdate _____ Chart number _____

PRACTICE NAME AND ADDRESS

AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Vaccine	Type of Vaccine ¹	Date vaccine given (mo/day/yr)	Funding Source (F,S,P) ²	Route ³ and Site ³	Vaccine		Statement (VIS)		Vaccinator ⁵ (signature or initials and title)
					Lot #	Mfr.	Date on VIS ⁴	Date given ⁴	
Tetanus, Diphtheria, Pertussis (e.g., Tdap, Td) Give IM. ³	Tdap	7/3/19	P	IM	LOT: H4A37 EXP: 10/18/21	Adacel® NDC 49281-400-50 (L) C5601AA (E) 12.MAR.2021			AM
					NDC 58160-815-43 Hepatitis A & Hepatitis B (Recombinant) Vaccine TWINRIX® 1 mL	NDC 58160-815-43 Hepatitis A & Hepatitis B (Recombinant) Vaccine TWINRIX 1 mL			AM
Hepatitis A (e.g., HepA, HepA-HepB®) Give IM. ³	Twinrix	7/3/19	P	IM	LOT: H4A37 EXP: 10/18/21				AM
	Twinrix	8/14/19	P	IM	LOT: H4A37 EXP: 10/18/21				AM
	Twinrix	2/18/20	P	IM	LOT: H4A37 EXP: 10/18/21				AM
Hepatitis B ¹ (e.g., Engerix-B, Recombi-vax HB, Heplisav-B, HepA-HepB®) Give IM. ³	Twinrix	7/3/19	P	IM	LOT: H4A37 EXP: 10/18/21				AM
	Twinrix	8/14/19	P	IM	LOT: H4A37 EXP: 10/18/21				AM
	Twinrix	2/18/20	P	IM	LOT: H4A37 EXP: 10/18/21				AM
Human papillomavirus (HPV2*, HPV4*, HPV9) Give IM. ³									
Measles, Mumps, Rubella (MMR) Give Subcut. ³									
Varicella (chickenpox,VAR) Give Subcut. ³									
Meningococcal ACWY (e.g., MenACWY, MPSV4*) Give MenACWY IM. ³									
Meningococcal B (e.g., MenB) Give MenB IM. ³									

*HPV2, HPV4, and MPSV4 vaccines are no longer available in the U.S., but should be included in patient records for historical purposes.

► See page 2 to record influenza, pneumococcal, zoster, Hib, and other vaccines (e.g., travel vaccines).

How to Complete this Record

- With the exception of hepatitis B vaccines, record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine; for hepatitis B vaccines, record the trade name (see table at right).
- Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
- Record the route by which the vaccine was given as either intramuscular (IM), subcutaneous (Subcut [SC]), intradermal (ID), intranasal (NAS), or oral (PO) and also the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).
- Record the publication date of each VIS as well as the date the VIS is given to the patient.
- To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.
- For combination vaccines, fill in a row for each antigen in the combination.

Abbreviation	Trade Name and Manufacturer
Tdap	Adacel (Sanofi Pasteur); Boostrix (GlaxoSmithKline [GSK])
Td	Decavac, Tenivac (Sanofi Pasteur); generic Td (MA Biological Labs)
HepA	Havrix (GSK); Vaqta (Merck)
For hepatitis B, see footnote #1.	Engerix-B (GSK); Recombivax HB (Merck); Heplisav-B (Dynavax)
HepA-HepB	Twinrix (GSK)
HPV2*	Cervarix (GSK)
HPV4*, HPV9	Gardasil, Gardasil 9 (Merck)
MMR	MMRII (Merck)
VAR	Varivax (Merck)
MenACWY	Menactra (Sanofi Pasteur); Menveo (GSK)
MPSV4*	Menomune (Sanofi Pasteur)
MenB	Bexsero (GSK); Trumenba (Pfizer)

CONTINUED ON THE NEXT PAGE ►

Technical content reviewed by the Centers for Disease Control and Prevention

Vaccine Administration Record for Adults (continued)

Patient name Otis R. Allen

Birthdate _____ Chart number _____

PRACTICE NAME AND ADDRESS

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Vaccine	Type of Vaccine ¹	Date vaccine given (mo/day/yr)	Funding Source (F,S,P) ²	Route ³ and Site ³	Vaccine		Vaccine Information Statement (VIS)		Vaccinator ⁵ (signature or initials and title)
					Lot #	Mfr.	Date on VIS ⁴	Date given ⁴	
Influenza (e.g., IIV3, IIV4, ccIIV4, RIV3, RIV4, LAIV4) Give IIV3, IIV4, ccIIV3, RIV3, and RIV4 IM. ³ Give LAIV4 NAS. ³									
Pneumococcal conjugate (e.g., PCV13) Give PCV13 IM. ³									
Pneumococcal polysaccharide (e.g., PPSV23) Give PPSV23 IM or Subcut. ³									
Zoster (shingles) Give RZV IM ³ Give ZVL Subcut ³									
Hib Give IM. ³									
Other	<u>Typhoid</u>	<u>7/3/16</u>	<u>P</u>	<u>IM</u>	<u>P13631M SP</u>	<u>SLZ</u>	<u>7/3/16</u>	<u>AM</u>	

► See page 1 to record Tdap/Td, hepatitis A, hepatitis B, HPV, MMR, varicella, MenACWY, and MenB vaccines.

How to Complete this Record

1. Record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine (see table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the route by which the vaccine was given as either intramuscular (IM), subcutaneous (Subcut [SC]), intradermal (ID), intranasal (NAS), or oral (PO) and also the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.

Abbreviation	Trade Name and Manufacturer
IIV3/IIV4 (inactivated influenza vaccine, trivalent or quadrivalent); ccIIV4 (cell culture-based inactivated influenza vaccine, quadrivalent); RIV3/RIV4 (inactivated recombinant influenza vaccine, trivalent or quadrivalent)	Fluarix, FluLaval (GSK); Afluria, Flud, Flucelvax, Fluvirin (Seqirus); Flublok, Fluzone, Fluzone Intradermal, Fluzone High-Dose (Sanofi Pasteur)
LAIV (live attenuated influenza vaccine, quadrivalent)	FluMist (MedImmune)
PCV13	Pneumovax 13 (Pfizer)
PPSV23	Pneumovax 23 (Merck)
RZV (recombinant zoster vaccine) ZVL (zoster vaccine, live)	Shingrix, RZV (GSK); Zostavax, ZVL (Merck)
Hib	ActHIB (Sanofi Pasteur); Hiberix (GSK); PedvaxHib (Merck)

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Otis R. Allen

DATE OF BIRTH 8 / 14 / 19
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to <u>medications</u> , food, a vaccine component, or latex? <u>PCN, gluten</u>	☒	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	☐	☒	☐
5. Do you, or does a close family member, have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☒	☐	☐

FORM COMPLETED BY Otis R. Allen DATE 8/14/2019
FORM REVIEWED BY W. H. G. CRN DATE 8/14/2019

Did you bring your immunization record card with you? yes ☐ no ☒

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☒	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐

FORM COMPLETED BY _____

DATE 7/3/19

FORM REVIEWED BY _____

DATE 7/3/19

Did you bring your immunization record card with you?

yes ☐ no ☒

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex? Penicillin	☒	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐

FORM COMPLETED BY _____

DATE _____

FORM REVIEWED BY _____

DATE _____

Did you bring your immunization record card with you?

yes ☐ no ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.