

# ADOLESCENT & ADULT IMMUNIZATION RECORD

Clinic: \_\_\_\_\_

Name: John Neighbors

Date of Birth: 7/2/09 Record #: \_\_\_\_\_

Allergies: Peanut, Tree nuts Reactions: \_\_\_\_\_

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

| Vaccine                   | Date Admin |     |    | Age at the time | VIS Form Given |    |    | Manuf Abbr* | Lot Number | 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                      |            |     |    |                 | Tdap           |    |    |             |            | 0.5cc |              | IM    |                                               |
| 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       |            |     |    |                 | MMR            |    |    |             |            | 0.5cc |              | SQ    |                                               |
| 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: over

[illegible][illegible][illegible][illegible]

# Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME John Neighbors  
DATE OF BIRTH 07 / 02 / 09  
month day year

**For parents/guardians:** The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child 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. Is the child sick today?                                                                                                                                                                                                                                  | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| 2. Does the child have allergies to medications, food, a vaccine component, or latex?                                                                                                                                                                        | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 3. Has the child had a serious reaction to a vaccine in the past?                                                                                                                                                                                            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| 4. Does the child have lung, heart, kidney or metabolic disease (e.g., diabetes), <u>asthma</u> , a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?          | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?                                                                                                | N/A                                 | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| 6. If your child is a baby, have you ever been told he or she has had intussusception?                                                                                                                                                                       | N/A                                 | <input type="checkbox"/>            | <input type="checkbox"/>            |
| 7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?                                                                                                                                            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| 8. Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems?                                                                                                                                                   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| 9. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| 10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?                                                                                                           | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| 11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?                                                                                                                                                         | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| 12. Has the child received vaccinations in the past 4 weeks?                                                                                                                                                                                                 | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |

FORM COMPLETED BY Phillip Neighbors DATE 02/12/2020  
FORM REVIEWED BY [Signature] DATE 2/12/20

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

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.