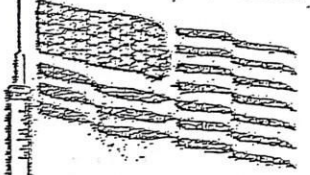


# ADOLESCENT & ADULT IMMUNIZATION RECORD

CLINIC:

Protect Our Future!



Name: Bailey Bell

Date of birth: 9/23/97 Record # \_\_\_\_\_

Allergies: NKMA Reactions: \_\_\_\_\_

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

Immunize!

| 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 |                 |                |             |            |       |              |       |                                               |
| 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          |             |            |       |              | SQ    |                                               |
| IPV                       |            |     |    |                 | Polio          |             |            |       |              | SQ    |                                               |
| IPV                       |            |     |    |                 | Polio          |             |            |       |              | SQ    |                                               |
| PPV23                     |            |     |    |                 | PPV            |             |            |       |              | IM    |                                               |
| PPV23                     |            |     |    |                 | PPV            |             |            |       |              | IM    |                                               |
| Hepatitis A               | 4          | 28  | 17 | 19              | Hep A          | 7           | 16         | 1.0   | LD           | IM    | Am                                            |
| 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    |                                               |

NDC 0006-4096-01  
1 Single-dose -500/1-ml Syringe  
(HEPATITIS A VACCINE, INACTIVATED)  
VAD01A  
ADULT  
Rx only  
SHAKE WELL BEFORE USING.  
Do not inject intravenously, intradermally or subcutaneously.  
Store at 2-8°C (36-46°F). DO NOT FREEZE.  
U.S. Govt. Lic. No. 12007  
Merck and Co., Inc. (a subsidiary of Merck & Co., Inc.)

Lot Exp.  
N005605 08APR2018

\* 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: \_\_\_\_\_

### \*\*\*Provider Information

[illegible]

## Tuberculin Test

[illegible]

### Titer Test Results for Non Susceptibility (IgM)

[illegible][illegible]

# 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?                                                                                                                                                                                                                                             | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have allergies to medications, food, a vaccine component, or latex?                                                                                                                                                                                      | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a serious reaction after receiving a vaccination?                                                                                                                                                                                             | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 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?                                                                                           | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?                                                                                                                                                                                     | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a seizure or a brain or other nervous system problem?                                                                                                                                                                                              | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 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?                                                                                                                   | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?                                                                                                                                                               | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you received any vaccinations in the past 4 weeks?                                                                                                                                                                                                        | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

FORM COMPLETED BY Bailey Bell DATE 04-28-11

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 health care provider records all your vaccinations on it.