SAMPLE IMMUNIZATION RECORD

This is a SAMPLE immunization record form. If reproduced for use by a college or university health center, please insert your health center's contact information. This form should not be returned to ACHA.

PART I

Name ______________________________________ ______________________________________
First Name Middle Name

____
Last Name

Address ____
Street City State Zip

Date of Entry ____/________ Date of Birth ____/____/________ School ID# ________________________
M Y M D Y

Status: Part-time _____ Full-time _____ Graduate _____ Undergraduate _____ Professional _____

____

PART II: TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

All information must be in English.

A. MMR (MEASLES, MUMPS, RUBELLA)

1. Dose 1 given at age 12 months or later . ... #1 ____/____/________
M D Y
2. Dose 2 given at least 28 days after first dose . ... #2 ____/____/________
M D Y

B. MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135)

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).
   a. Dose #1 ____/____/________ b. Dose #2 ____/____/________
   M D Y M D Y
2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available). Date ____/____/________
M D Y

C. SEROGROUP B MENINGOCOCCAL

The vaccine series must be completed with the same vaccine.

1. MenB-RC (Bexsero) __ routine _____outbreak –related
   a. Dose #1 ____/____/________ b. Dose #2 ____/____/________
   M D Y M D Y

OR

2. MenB-FHbp (Trumenba) __routine ___outbreak-related
   a. Dose #1 ____/____/________ b. Dose #2 ____/____/________ c. Dose #3 ____/____/________
   M D Y M D Y M D Y

D. TETANUS, DIPHTHERIA, PERTUSSIS

1. Primary series completed? Yes ___ No ___ Date of <u>last</u> dose in series: ____/____/________
M D Y
2. Date of most recent booster dose: ____/____/________ Type of booster: Td _____ Tdap _____
M D Y

E. INFLUENZA

Trivalent (IIV3) _____ Quadrivalent (IIV4) _____ Recombinant (RIV4) _____ Live attenuated influenza vaccine (LAIV) _____
Adjuvanted inactivated influenza (aIIV3) _____

Date of last dose: ____/____/________
M D Y

F. HEPATITIS A

1. Immunization (hepatitis A)

a. Dose #1 ____/____/________ (M D Y)   b. Dose #2 ____/____/________ (M D Y)

2. Immunization (Combined hepatitis A and B vaccine)

a. Dose #1 ____/____/________ (M D Y)   b. Dose #2 ____/____/________ (M D Y)   c. Dose #3 ____/____/________ (M D Y)

G. HEPATITIS B

Heplisav-B (2 dose series) is not interchangeable with other hepatitis B vaccines (3 dose series) but can substituted for dose #2 and #3.

1. Immunization (hepatitis B)

a. Dose #1 ____/____/________ (M D Y)
Adult formulation ___ Child formulation ____
HepB-CpG (Heplisav-B) ____

b. Dose #2 ____/____/________ (M D Y)
Adult formulation ____ Child formulation____
HepB-CpG (Heplisav-B) ____

c. Dose #3 ____/____/________ (M D Y)
Adult formulation ____ Child formulation ____
HepB-CpG (Heplisav-B) ____

2. Immunization (Combined hepatitis A and B vaccine)

a. Dose #1 ____/____/________ (M D Y)   b. Dose #2 ____/____/________ (M D Y)   c. Dose #3 ____/____/________ (M D Y)

3. Hepatitis B surface antibody (recommended for individuals born in or whose mother was born in a hepatitis B endemic country and/or men who have sex with men; required for health science students).

Date ____/____/________   Result: Reactive ________   Non-reactive ________

H. HUMAN PAPILLOMAVIRUS VACCINE

Immunization (indicate which preparation, if known) Quadrivalent (HPV4) _____ or Bivalent (HPV2) _____ or 9-valent (HPV9) ____

a. Dose #1 ____/____/________ (M D Y)   b. Dose #2 ____/____/________ (M D Y)   c. Dose #3 ____/____/________ (M D Y)

I. VARICELLA

1. Immunization

a. Dose #1 . ... #1 ____/____/________ (M D Y)

b. Dose #2 given at least 12 weeks after first dose ages 1–12 years.. #2 ____/____/________ (M D Y)
and at least 4 weeks after first dose if age 13 years or older.

2. History of Disease Yes ___ No ___ or Birth in U.S. before 1980 Yes ___ No ___

J. PNEUMOCOCCAL POLYSACCHARIDE VACCINE

PCV 13 _______ Date ____/____/________ (M D Y)   PPSV 23 _______ Date ____/____/________ (M D Y)

K. POLIO

1. OPV alone (oral Sabin three doses): #1 ____/____/________ (M D Y)   #2 ____/____/________ (M D Y)   #3 ____/____/________ (M D Y)

2. IPV/OPV sequential: IPV #1 ____/____/________ (M D Y)   IPV #2 ____/____/________ (M D Y)   OPV #3 ____/____/________ (M D Y)   OPV #4 ____/____/________ (M D Y)

3. IPV alone (injected Salk four doses): #1 ____/____/________ (M D Y)   #2 ____/____/________ (M D Y)   #3 ____/____/________ (M D Y)   #4____/____/________ (M D Y)

HEALTH CARE PROVIDER

Name ____ Signature ____

Address ____ Phone (__________)______________________________

END of SAMPLE FORM

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