

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 last 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 b. Dose #2 ___/___/___ M D Y c. Dose #3 ___/___/___ M D Y
Adult formulation ___ Child formulation ___ Adult formulation ___ Child formulation ___ Adult formulation ___ Child formulation ___
HepB-CpG (Heplisav-B) ___ HepB-CpG (Heplisav-B) ___ 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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