

# Adult Immunization Record and History

PATIENT NAME (Last Name, First Name, Middle Initial)		NUMBER
BIRTHDATE	<input type="checkbox"/> Male <input type="checkbox"/> Female	PRACTICE NAME/ADDRESS
KNOWN REACTIONS TO VACCINES/ALLERGIES		

**If a combination vaccine (e.g., HepB + HepA) is used, record dose in each section.**

VACCINE <small>Circle one</small>	DATE GIVEN*	MANUFACTURER AND LOT NUMBER	ADMINISTERED BY	SITE**	VACCINE	DATE GIVEN*	MANUFACTURER AND LOT NUMBER	ADMINISTERED BY	SITE**
				VIS I.D.†					VIS I.D.†
10 year <b>Tdap/Td</b>				<i>IM</i>	<b>MMR 1</b>				<i>SC</i>
10 year <b>Tdap/Td</b>				<i>IM</i>	<b>MMR 2</b>				<i>SC</i>
10 year <b>Tdap/Td</b>				<i>IM</i>	<b>MCV4/ MPSV4</b> <small>(meningococcal)</small>				<i>IM or SC</i>
10 year <b>Tdap/Td</b>				<i>IM</i>					
<b>Pneumo. Poly.</b>				<i>IM or SC</i>	<b>Varicella 1</b>				<i>SC</i>
					<b>Varicella 2</b>				<i>SC</i>
<b>HepA 1</b>				<i>IM</i>	<input type="checkbox"/> Check here if patient had chickenpox disease and does not need vaccine.				
<b>HepA 2</b>				<i>IM</i>	<b>Shingles</b>				<i>SC</i>
<b>HepB 1</b>				<i>IM</i>	<b>TRAVEL/OTHER VACCINES</b>				
<b>HepB 2</b>				<i>IM</i>					
<b>HepB 3</b>				<i>IM</i>					
<b>HPV 1<sup>§</sup></b> <small>(for women only)</small>				<i>IM</i>					
<b>HPV 2<sup>§</sup></b> <small>(for women only)</small>				<i>IM</i>					
<b>HPV 3<sup>§</sup></b> <small>(for women only)</small>				<i>IM</i>					
<b>TIV/LAIV</b> <small>(Flu)</small>				<i>IM/Nasal</i>					
<b>TIV/LAIV</b> <small>(Flu)</small>				<i>IM/Nasal</i>	Travel/Other Vaccines continued on back				
<b>TIV/LAIV</b> <small>(Flu)</small>				<i>IM/Nasal</i>					
<b>TIV/LAIV</b> <small>(Flu)</small>				<i>IM/Nasal</i>					
<b>TIV/LAIV</b> <small>(Flu)</small>				<i>IM/Nasal</i>					
<b>TIV/LAIV</b> <small>(Flu)</small>				<i>IM/Nasal</i>					

Influenza continued on back

\* **Date Given** is the date you gave the patient the Vaccine Information Statement (VIS) and you administered the vaccine. If you are recording a vaccine given elsewhere, record date dose was given, write in "elsewhere" or "transcribed," and/or name of provider.

\*\* **Site:** Abbreviations are LD=left deltoid or left outer upper arm, RD=right deltoid or right outer upper arm. (See over for illustrations.) Recommended route indicated by italics. Most adult vaccines are given IM (intramuscular) in the deltoid. MMR, Varicella, and MPSV4 vaccines are given SC (subcutaneous) in the fatty tissue of outer upper arm. MCV4 is given IM (intramuscular). Pneumococcal Polysaccharide can be given either IM or SC.

§ **Human Papillomavirus (HPV)** 3 doses for women through age 26 years.

† **VIS**—Vaccine Information Statement. Each VIS has an issue date in the lower corner; record the VIS issue date here. The VIS should be given to the patient before each dose of vaccine is administered; they are required by law for Td, HepB, MMR, and Varicella. Each VIS can be downloaded from [www.cdc.gov/nip/publications/VIS](http://www.cdc.gov/nip/publications/VIS).

# Adult Immunization Record and History, continued

If a combination vaccine (e.g., HepB + HepA) is used, record dose in each section.

VACCINE	DATE GIVEN*	MANUFACTURER AND LOT NUMBER	ADMINISTERED BY	SITE**	VACCINE	DATE GIVEN*	MANUFACTURER AND LOT NUMBER	ADMINISTERED BY	SITE**
				VIS I.D.†					VIS I.D.†
TIV/LAIV (Flu)				IM/Nasal					
TIV/LAIV (Flu)				IM/Nasal					
TIV/LAIV (Flu)				IM/Nasal					
TIV/LAIV (Flu)				IM/Nasal					
TIV/LAIV (Flu)				IM/Nasal					
TIV/LAIV (Flu)				IM/Nasal					
TIV/LAIV (Flu)				IM/Nasal					
TIV/LAIV (Flu)				IM/Nasal					
TIV/LAIV (Flu)				IM/Nasal					
TIV/LAIV (Flu)				IM/Nasal					
TIV/LAIV (Flu)				IM/Nasal					
TIV/LAIV (Flu)				IM/Nasal					
TIV/LAIV (Flu)				IM/Nasal					
TIV/LAIV (Flu)				IM/Nasal					
TIV/LAIV (Flu)				IM/Nasal					
TIV/LAIV (Flu)				IM/Nasal					
TIV/LAIV (Flu)				IM/Nasal					
TIV/LAIV (Flu)				IM/Nasal					

## IM in Deltoid



90° angle  
1" or longer needle

## SC in Outer Arm



45° angle  
5/8" needle