

Patient Immunization and Vaccination History Form

Please complete all sections as accurately as possible. This form is intended for print and manual record-keeping.

Patient Information

Full Name: Date of Birth (MM/DD/YYYY):
Phone Number: Medical Record Number (MRN):
Address:

Vaccination History Record

Vaccine / Toxoid	Date Administered (MM/DD/YYYY)	Dose (e.g., 1st, 2nd, Booster)	Lot Number	Manufacturer	Clinic / Healthcare Provider
COVID-19	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
COVID-19	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Influenza (Flu - Seasonal)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Tdap (Tetanus, Diphtheria, Pertussis)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
MMR (Measles, Mumps, Rubella)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Varicella (Chickenpox)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hepatitis B	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hepatitis A	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pneumococcal (PPSV23 / PCV13)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Meningococcal	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other: <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other: <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Medical History Notes & Allergies

Known Vaccine Allergies / Adverse Reactions:
Relevant Contraindications or Medical Conditions:

Verification and Signature

I certify that the above immunization history is correct and complete to the best of my knowledge.

Patient / Guardian Signature: Date:
Healthcare Provider Signature: Date: