



ADULT VACCINE ADMINISTRATION RECORD

Philadelphia Department of Public Health
Division of Disease Control, Immunization Program
Phone: (215) 685-6668 Fax: (215) 685-6806

Provider Name/Address:

Provider Phone:

Patient Name: _____ Date of Birth: _____ Record#: _____

Patient Address: _____ Tel: _____

The person who administered the following vaccines certifies by his/her signature below that the appropriate Vaccine Information Statement (VIS) for each vaccine administered was given to the patient named above or to his/her parent/guardian/caretaker at the time of each immunization.

Please note when a combination vaccine is used.

VACCINE	Date Given M/D/Y	Site*	Vaccine Manufacturer	Vaccine Lot #	VIS Publication Dates	Signature of Vaccine Administrator
Tdap						
Td						
Hep B OR A+B #1 (circle one)						
Hep B OR A+B #2						
Hep B OR A+B #3						
Hep A #1						
Hep A #2						
HPV #1						
HPV #2						
HPV #3						
Pneumococcal						
MMR						
MMR						
Varicella #1						
Varicella #2						
Zoster						
Meningococcal						
Other						

*Site Given LEGEND: RA=Right Arm; LA=Left Arm, RT=Right Thigh, LT=Left Thigh, O=Oral N=Nasal

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