VACCINATION CLINIC: VACCINE ADMINISTRATION RECORD

Clinic Name and Address:						
Contact Person:	Phone Number:					
	e, provide the patient or legal representative with the appropriate VIS for each dose of vaccine illable on-line for all vaccines and in many languages, at www.immunize.org/vis .					
Use a separate line for each dose of vaccine.						

Name	Age	Medicare or Insurance #	Date Vax Given	Type of Vax	Vaccine Manufacturer	Vaccine Expiration Date & Lot Number	Dose	Route & Site*	Date VIS Given	Date on VIS	Vax Admin Initials

^{*}Route given: PO = oral, SC = subcutaneous, IM = intramuscular, IN= intranasal, ID = intradermal

^{*}Site given: RA = right arm, LA = left arm, RT = right thigh, LT = left thigh

Name(s) and Title(s) of Vaccine Administrator(s)	Initials	Name(s) and Title(s) of Vaccine Administrator(s)	Initials	Name(s) and Title(s) of Vaccine Administrator(s)	Initials