

adult vaccination record

Name _____ Date of Birth _____

Discuss the following vaccinations with your doctor to learn if you are at risk.
Have your doctor sign and date in the corresponding box to record the vaccination.

ROUTINE VACCINATIONS	DOCTOR'S SIGNATURE AND DATES OF VACCINATION					
Tetanus, diphtheria, pertussis (Td/Tdap)						
Influenza Vaccine (flu shot)						
Pneumococcal Vaccine (PPV or PCV)						
Measles, Mumps, Rubella						
Hepatitis B (3 shots)						
Hepatitis A (2 shots)						
Human Papillomavirus (HPV)						
Meningococcal (meningitis vaccine)						
Varicella (2 shots) (chickenpox)						
PPD or Tine Test (tuberculosis skin test)						
<i>Special or Travel Vaccination</i>						
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