

Clinic Name & Address

Adult Vaccine Administration Record

Rev.12-2010

Name: _____
(Last) (First) (Middle) (Jr/Sr/Other)

Date of Birth: ___/___/___ Gender: (circle) M F

Address: _____ City/Town: _____ State: _____ Zip: _____

Adults age 19 years and older are eligible to receive vaccines through Vermont Vaccines for Adults program.
 Document in each column. *Federal law requires documentation of current VIS provided to patient for each vaccination.*

Vaccine Type	Date Vaccine Administered & VIS Given	Route/Site (circle) [†]	Manu- facturer	Lot Number	VIS Publication Date	Administered By	
						Signature	Title
HepA #1		IM / RA LA					
HepA #2		IM / RA LA					
HepB #1		IM / RA LA					
HepB #2		IM / RA LA					
HepB #3		IM / RA LA					
HepA-HepB #1		IM / RA LA					
HepA-HepB #2		IM / RA LA					
HepA-HepB #3		IM / RA LA					
HPV4 #1		IM / RA LA					
HPV4 #2		IM / RA LA					
HPV4 #3		IM / RA LA					
MMR #1		SC / RA LA					
MMR #2		SC / RA LA					
PPSV23		IM / RA LA					
PPSV23		IM / RA LA					
Tdap		IM / RA LA					
Td		IM / RA LA					
Td		IM / RA LA					
Td		IM / RA LA					
VAR #1		SC / RA LA					
VAR #2		SC / RA LA					
ZOS		SC / RA LA					

Varicella Disease history, include date when known:

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Vaccine Type <small>(circle type)[†]</small>	Date Vaccine Administered & VIS Given	Route/Site <small>(circle)[†]</small>	Manufacturer	Lot Number	VIS Publication Date	Administered By	
						Signature	Title
TIV or LAIV		IM/ RA LA Intranasal					
TIV or LAIV		IM/ RA LA Intranasal					
TIV or LAIV		IM/ RA LA Intranasal					
TIV or LAIV		IM/ RA LA Intranasal					
TIV or LAIV		IM/ RA LA Intranasal					
TIV or LAIV		IM/ RA LA Intranasal					
TIV or LAIV		IM/ RA LA Intranasal					
TIV or LAIV		IM/ RA LA Intranasal					
TIV or LAIV		IM/ RA LA Intranasal					
TIV or LAIV		IM/ RA LA Intranasal					
TIV or LAIV		IM/ RA LA Intranasal					
TIV or LAIV		IM/ RA LA Intranasal					
TIV or LAIV		IM/ RA LA Intranasal					
TIV or LAIV		IM/ RA LA Intranasal					
TIV or LAIV		IM/ RA LA Intranasal					
TIV or LAIV		IM/ RA LA Intranasal					
TIV or LAIV		IM/ RA LA Intranasal					
Enter other vaccinations below:							

† Abbreviations
 TIV = Trivalent inactivated Influenza Vaccine
 LAIV = Live Attenuated Influenza Vaccine
 RA = Right Arm
 LA = Left Arm
 IM = Intramuscular
 SC = Subcutaneous

Immunization Program
 108 Cherry Street, P.O. Box 70
 Burlington, VT 05402-0070
 802-863-7638 or toll free
 800-640-4374 (VT only)

