Adolescent Immunization History

Name

_____

Date of Birth

____ / ____ / _____

ID Number

_____

Vaccine	Dose	Date Given	Lot Number	Clinic/Provider	Comments
Tdap (Tetanus, Diphtheria, Pertussis)	1	____ / ____ / _____	_____	_____	
HPV (Human Papillomavirus)	1	____ / ____ / _____	_____	_____	
HPV (Human Papillomavirus)	2	____ / ____ / _____	_____	_____	
Meningococcal ACWY	1	____ / ____ / _____	_____	_____	
Meningococcal B	1	____ / ____ / _____	_____	_____	
Influenza (Yearly)	-	____ / ____ / _____	_____	_____	
COVID-19	1	____ / ____ / _____	_____	_____	
Others	-	____ / ____ / _____	_____	_____	

Notes

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