

# Pediatric Immunization Record

Child's Name

Date of Birth

Sex

Parent/Guardian Name

Address

Contact Number

## Immunization Record

Vaccine	Date Given	Lot Number	Provider Initials	Notes
Hepatitis B				
Rotavirus				
DTP/DTaP/DT/Td/Tdap				
Hib				
Polio (IPV/OPV)				
Pneumococcal				
MMR				
Varicella				
Hepatitis A				
Meningococcal				
HPV				
Influenza				
Other				

## Comments / Medical Provider Notes:

Reviewed By

Date Reviewed

Signature