

## IMMUNIZATION RECORD FORM

**Patient Name** \_\_\_\_\_ **Sex** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Mother** \_\_\_\_\_ **Physician** \_\_\_\_\_

<b>Vaccine</b>	<b>Dose, site, route of administration</b>	<b>Date given</b>	<b>Manufacturer lot number</b>	<b>Physician</b>	<b>Next dose due</b>
DPT or T or DT					
HIB					
Polio					
MMR					
OTHER					