VACCINE ADMINISTRATION RECORD

Jollyville Pediatrics
11851 Jollyville Road, Suite 204
Austin, Texas 78759
Phone: 512.219.5550
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Patient Name: ______________________________
Date of Birth: ________________________

A copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Material(s) has been provided today. I/We have read, or have had explained, the information about the diseases and the vaccines listed below. There was an opportunity to ask questions and any questions were answered satisfactorily. I/We believe that I/We understand the benefits and risks of the vaccine cited, and ask that the vaccine(s) listed below be given to me/us or to the person named above, for whom I/We are authorized to make this request.

VACCINE	Age	Date Given M/D/Y	Site Given	Vaccine lot Number	Vaccine manufacturer	VIS Date	Init.*	Parent or Guardian Signature
Hep. B – 1 ___ mcg								
Hep. B – 2 ___ mcg								
Hep. B – 3 ___ mcg								
DtaP • DT • Td- 1								
DtaP • DT • Td- 2								
DtaP • DT • Td- 3								
DtaP • DT • Td- 4								
DtaP • DT • Td- 5								
Td Booster								
Hib - 1								
Hib - 2								
Hib - 3								
Hib - 4								
Pneum. Conj (PCV)- 1								
Pneum. Conj (PCV)- 2								
Pneum. Conj (PCV)- 3								
Pneum. Conj (PCV)- 4								
IPV- 1								
IPV- 2								
IPV- 3								
IPV- 4								
MMR - 1								
MMR- 2								
Varicella- 1								
Varicella- 2								
Hepatitis A- 1								
Hepatitis A- 2								
Influenza								
Rotovirus								
Prevnar								

**Initials & Signature of Vaccine Administrator		Date	Date Read	Results / Initials
•	PPD			
•	PPD			
•	PPD			