ADVANTAGE
medical professionals

Immunization Record Documentation

Clinician's Name (Printed): _____ DOB: _____

1) Vaccination Received: _____ Date Administered: _____

Injection Site: _____ Lot #: _____ Expiration: _____

2) Vaccination Received: _____ Date Administered: _____

Injection Site: _____ Lot #: _____ Expiration: _____

3) Vaccination Received: _____ Date Administered: _____

Injection Site: _____ Lot #: _____ Expiration: _____

4) Vaccination Received: _____ Date Administered: _____

Injection Site: _____ Lot #: _____ Expiration: _____

Facility Information: _____

Facility Name

_____

Address

_____

City *State* *Zip*

Administered by (Print Name): _____

Signature: _____ Date: _____

Clinician's Signature: _____ Date: _____