

Adult Immunization Record

Name _____
 Address _____
 Birthdate _____
 Social Security Number _____

Vaccine	Dose	Date	Doctor/Clinic
Influenza	(given annually)	_____	_____
		_____	_____
		_____	_____
		_____	_____
		_____	_____
Pneumococcal (A repeat dose may be needed for those at highest risk.*)			
	1	_____	_____
	2	_____	_____
Varicella*	1	_____	_____
	2	_____	_____
Hepatitis A*	1	_____	_____
	2	_____	_____
Hepatitis B*	1	_____	_____
	2	_____	_____
	3	_____	_____
MMR (Measles-Mumps-Rubella)			
	1	_____	_____
	2	_____	_____
Td (Boosters are needed every 10 years for life.)			
	1	_____	_____
	2	_____	_____
	3	_____	_____
	Booster	_____	_____
	Booster	_____	_____
	Booster	_____	_____
Other	_____	_____	_____

*Consult your doctor to determine your susceptibility or level of risk. Source: **National Coalition for Adult Immunization**
www.pccdocs.com