AMERIGROUP Community Care

Addressograph

Immunization Record

"I have read or have had explained to me information about the disease and the vaccines listed below. I believe I understand the benefits and risks of the vaccines cited, and ask that the vaccine(s) listed below be given to me or to the person named above for whom I am authorized to make this request."

Dose	Date	Time	Mf. /lot no. /expiration date	Site group	Route	Adm. by	Signature of parent or guardian
1. DPT							
2.							
3.							
4.							
5.							
1. OPV							
2.							
3.							
4.							
1. DT/dt							
2.							
3.							
4.							
1. MMR							
2.							
1. VARICELLA							
2.							
3.							
1. HIB/PVAX							
2.							
3.							
4.							
1. FLU							
2.							
3.							
1. PNEUMO							
2.							
1. HEP B							
2.							
3.							
1. PPD							
2.							
3.							
4.							
1. Td							
2.							
3.							
1. OTHER							
2.							
3.							