Name _____ Sex _____ Birthdate _____

Vaccine		Date Given Mo	Day	Year	Clinic Name	Admin. Initials
Hepatitis B	1					
	2					
	3					
	4					
Rotavirus ☐ Rotarix ☐ RotaTeq	1					
	2					
	3					
DTaP/ DT/Td/ Tdap ☐ Kinrix ☐ Pediarix ☐ Pentacel ☐ Quadracel		DTaP	DT	Td	Tdap					
	1									
	2									
	3									
	4									
	5									
Hib (*Haemophilus influenzae* type b) ☐ Pedvax ☐ ActHib ☐ Hiberix	1					
	2					
	3					
	4					
Pneumococcal ☐ PCV13 ☐ PPSV23	1					
	2					
	3					
	4					
Polio ☐ IPOL ☐ Kinrix ☐ Quadracel	1					
	2					
	3					
	4					
MMR (Measles, Mumps, Rubella) ☐ MMR II ☐ ProQuad	1					
	2					
Varicella Date of Disease: _____	1					
	2					
Hepatitis A	1					
	2					
Meningococcal ☐ Menactra ☐ Menveo	1					
	2					
HPV	1					
	2					
	3					

Other Vaccines (i.e. Flu, travel vaccines, etc.)	Date Given	Clinic Name	Admin. Initials
Meningococcal B			
Meningococcal B			
Flu			
Flu			
Flu			
Other			
Other			
Other			

Recommended Childhood Immunization Schedule

	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	2-3 years	4-6 years
Hep B	■	■			■			■			
Rotavirus			■	■	■						
DTaP			■	■	■		■	■			■
Hib			■	■	■	■					
PCV			■	■	■	■					
IPV			■	■	■			■			■
Influenza					■						
MMR						■		■			■
Varicella						■		■			■
Hep A						■					

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[Idaho Department of Health and Welfare][11/2016].[12637]: 30,000 units/[.07] per unit

Childhood Immunization Record

Name _____

Birthdate _____ Sex _____

Parent/Guardian _____

Allergies _____