Adult Vaccine Administration Record

Please complete and sign this form. If you do not fill it out completely, you may be denied immunization services. The form may be kept in your (or your child's) medical file. This information is private and will not be shared with anyone except healthcare agencies, childcare facilities, and schools to help them provide immunization services, make sure immunization requirements have been met, and prevent disease by monitoring immunization needs. These agencies may include the Minnesota Department of Health; licensed healthcare professionals such as doctors and nurses; health insurers; Head Start programs; county public health agencies; community action agencies; and licensed healthcare facilities such as hospitals.

Information About Person to Receive Vaccine (please print)

Name: Last		First		Middle Initial
Address: Street	City	County	State	Zip
Birthdate	Age	Patient Medicare Health Insurance Claim Number (if applicable)		

Vaccines to be given:

- ☐ Hep A
- ☐ Hep B
- ☐ Polio
- ☐ Td
- ☐ Tdap
- ☐ MMR
- ☐ HPV
- ☐ Varicella
- ☐ Herpes-zoster

Influenza:
- ☐ IIV
- ☐ LAIV

Pneumococcal:
- ☐ PPV23

Meningococcal:
- ☐ MCV4
- ☐ MPSV4

☐ Other: ____________________

I have read or have had explained to me the fact sheet(s) called "What You Need to Know," also known as "vaccine information statements," about the vaccine(s) and disease(s) indicated above. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks and ask that the vaccine(s) be given to me or the person named above.

Signature of person to receive vaccine or authorized representative or legal guardian:

X ______________________________ Date: ______________

For Clinic/Office Use

Clinic/office address:

Date vaccine(s) administered:

Vaccine type				
Manufacturer				
Lot number				
Site of injection/route				
Given by (initials*)				
Date on VIS				
Date VIS given				

*Signature and title of person(s) administering vaccine

______________________ ______________________

______________________ ______________________

Note to providers: Federal and Minnesota state law do **not** require signatures acknowledging receipt of vaccine information statements (VISs). However, to conform with your own agency policies, you may wish to use this form during clinics to record the signature of the vaccinee or authorized representative as well as NCVIA requirements.