IMMUNIZATION RECORD MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

CHILD'S NAME (LAST, FIRST, MI)	DATE OF BIRTH

	DATES GIVEN					
DOSE	**1**	**2**	**3**	**4**	**5**	**6**
DTaP						
DT						
Hib						
Polio						
Hepatitis B						
MMR						
Varicella						
Tdap						
Td						
Pneumococcal						
Hepatitis A						
Influenza						
Meningococcal						
Rotavirus						
HPV						
Other						

NAME OF PHYSICIAN OR RECOGNIZED HEALTH FACILITY (PLEASE PRINT OR TYPE):

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DATE	SPECIAL NOTES

IF AN ADVERSE REACTION IS OBSERVED, PLEASE REPORT TO CDC THROUGH VAERS ONLINE: https://vaers.hhs.gov

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