Practice Name and Address:

State of Rhode Island
Adult Vaccine Administration Record

Patient Name: _____

Date of Birth: __ __/___ _/_ _ __ **Record Number:** _____

Vaccine	Date Administered			Site	Vaccine		Vaccine Information Statement (VIS)		Signature Of Person Administering Vaccine
	Mo	Day	Yr	RA/LA RT/LT	Lot #	Mfr.	Date on VIS *	Date VIS Given *	
Tetanus, diphtheria, pertussis (Tdap) **or** **Tetanus, Diphtheria (Td)** Give IM									
Human Papillomavirus (HPV) *Give IM*									
Measles, Mumps, Rubella (MMR) *Give SC*									
Varicella (Var) *Give SC*									
Pneumococcal Polysaccharide (PPV) *Give SC or IM*									
Hepatitis B (Hep B) *Give IM*									
Hepatitis A (Hep A) *Give IM*									
Meningococcal *Give MCV4 IM* *Give MPSV4 SC*									
Zoster *Give SC*									
Influenza **TIV** *Give IM* **LAIV** *Give Intranasally*									
Other									

TB Test Date							
Result							