Adult Immunization Record

(Both you and your doctor should keep a copy of this record)

Last Name: _____ First Name: _____

Birth Date: _____/_____/_____
Month Day Year

	Type of Vaccine	Date Given Mo/day/yr	Doctor or Clinic	Date Next Dose Due
Tetanus, diphtheria, pertussis (Td, Tdap)				
Influenza (seasonal flu)				
H1N1 ("swine flu")				
Human papillomavirus (HPV)				
Hepatitis B				
Hepatitis A				
Measles, Mumps, Rubella (MMR)				
Varicella (chickenpox)				
Zoster (shingles)				
Meningococcal (meningitis)				
Other				