State of Rhode Island
Adult Vaccine Administration Record

Practice Name and Address:

Patient Name:_____

Date of Birth ___/___/____ **Record Number**_____

Vaccine Name	Date Given	Site	Vaccine		Vaccine Information Statement (VIS)		Signature or Initials of
	mm/dd/yyyy	RA/LA RT/LT	Lot #	Mfr.	Date on VIS	Date VIS given	Vaccinator
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 (PPSV23) ***Give SC or IM***							
Pneumococcal Conjugate PCV13 ***Give IM***							
Hepatitis B (Hep B) ***Give IM***							
Hepatitis A (Hep A) ***Give IM***							
Meningococcal ACWY Conjugate (MCV4) ***Give IM***							
Meningococcal B (MenB) ***Give IM***							
Influenza **TIV** ***Give IM*** **LAIV** ***Give Intranasally***							
Zoster (HZV) ***Give SC***							
Other							
TB Test Date							
Results							