

RECORD OF IMMUNIZATIONS

Patient's Name: _____

Birth Date: _____

EDGEWOOD CENTER PEDIATRICS, P.C.
8896 Commerce Rd. Suite 5
Commerce, Michigan 48382

I have read, or had explained to me, information about the diseases and the vaccines listed below. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine to be administered, and ask that these vaccine(s) be given to me or to the person named (for whom I am authorized to make this request).

Vaccine	Date Given M/D/Y	A g e	Site Given	Vaccine manufacturer	Vaccine lot number	Signature of vaccine administrator	Signature of parent or guardian
PEDIARIX (DTaP, IPV, Hep B) (IM)							
PEDIARIX (DTaP, IPV, Hep B) (IM)							
PEDIARIX (DTaP, IPV, Hep B) (IM)							
Hib # 1 (IM)							
Hib # 2 (IM)							
Hib # 3 (IM)							
Hib # 4 (IM)							
Pneum Conj (13) # 1 (IM)							
Pneum Conj (13) # 2 (IM)							
Pneum Conj (13) # 3 (IM)							
Pneum Conj (13) # 4 (IM)							
Rotateq #1 (PO)							
Rotateq #2 (PO)							
Rotateq #3 (PO)							
DTaP • DT • Td # 1 (IM)							
DTaP • DT • Td # 2 (IM)							
DTaP • DT • Td # 3 (IM)							
DTaP • DT • Td # 4 (IM)							
DTaP • DT • Td # 5 (IM)							
Tdap (IM)							
Meningococcal (IM)							
Polio # 1 (SQ • IM)							
Polio # 2 (SQ • IM)							
Polio # 3 (SQ • IM)							
Polio # 4 (SQ • IM)							
Hepatitis A #1 (IM)							
Hepatitis A #2 (IM)							
MMR # 1 (SQ)							
MMR # 2 (SQ)							
Varivax #1 (SQ)							
Varivax #2 (SQ)							
Gardasil #1 9 (IM)							
Gardasil #2 9 (IM)							
Gardasil #3 9 (IM)							

