

Notification of Vaccination Letter

Dear Doctor or Provider at _____

PATIENT'S PRIMARY CARE CLINIC

We recently provided vaccination services to your patient. We want to make certain that you have information about the vaccines we administered so you can update your patient's medical record. Please contact us if you have any questions about this information.

We provided the patient (or parent/guardian) with a written record of the vaccination(s) given.

We entered information about the vaccine(s) we administered in the regional or state immunization information system.

Patient's name _____ Patient's birthdate _____
(MM/DD/YR)

(For a child, parent/guardian name) _____ Parent/guardian birthdate _____
(MM/DD/YR)

The vaccine(s) we administered on _____ is/are checked below.
DATE

VACCINES ADMINISTERED

Hepatitis B]

- ☐ Engerix-B, Recombivax HB
dose (circle one): 0.5 mL 1.0 mL
- ☐ HepIsav-B (age 18 yrs and older)

- ☐ DTaP (age 6 yrs and younger)
- ☐ DTaP-HepB-IPV (Pediarix)
- ☐ DTaP-IPV (Kinrix, Quadracel)
- ☐ DTaP-IPV/Hib (Pentacel)
- ☐ DT (through age 6 yrs)
- ☐ Tdap (age 7 yrs and older)
- ☐ Td (age 7 yrs and older)

Hib (monovalent)

- ☐ ActHIB
- ☐ Hiberix
- ☐ PedvaxHIB

- ☐ IPV (Polio)
- ☐ Pneumococcal conjugate (PCV)
(Prenar 13)
- ☐ Pneumococcal polysaccharide
(PPSV) (Pneumovax 23)

Rotavirus

- ☐ RV1 (Rotarix)
- ☐ RV5 (RotaTeq)

- ☐ Human papillomavirus (HPV)
(Gardasil 9)
- ☐ MMR
- ☐ Varicella (chickenpox) (Varivax)

- ☐ MMRV (ProQuad)

- ☐ Hepatitis A (Havrix; Vaqta)
dose (circle one): 0.5 mL 1.0 mL

- ☐ HepA-HepB (Twinrix)

Meningococcal ACWY

- ☐ MenACWY (Menactra, Menveo)

Meningococcal B

- ☐ Bexsero
- ☐ Trumenba

- ☐ Influenza

BRAND _____
DOSE (mL) _____
ROUTE (circle one): IM ID NAS

Zoster (shingles)

- ☐ RZV (Shingrix, recombinant)
- ☐ ZVL (Zostavax, live)

- ☐ Other _____

NAME OF CLINIC PROVIDING SERVICES

ADDRESS

CITY/STATE/ZIP

CLINIC CONTACT PERSON

E-MAIL ADDRESS OR FAX NUMBER

PHONE NUMBER