**Date:** _____

**Patient Name:** _____

**Patient Age:** _____

## Vaccines recommended for you:

- ☐ Influenza (❍Standard, ❍High Dose, ❍Other specifications: _____)
- ☐ COVID-19
- ☐ Pneumococcal (❍PCV15, ❍PCV20, ❍PPSV23)
- ☐ Tetanus, diphtheria, pertussis (❍Tdap, ❍Td)
- ☐ Measles, Mumps, Rubella (MMR)
- ☐ Human Papillomavirus (HPV)
- ☐ Zoster
- ☐ Hepatitis A (HepA)
- ☐ Hepatitis B (HepB)
- ☐ Meningococcal A (MenA)
- ☐ Meningococcal B (MenB)
- ☐ Varicella (VAR)
- ☐ Respiratory Syncytial Virus (RSV)
- ☐ Other Vaccine(s): _____

_____

## Information for Vaccinating Practitioner:

Additional Patient Information (e.g., contraindications, allergies, etc.):

Please report vaccine administration information to the state Immunization Information System (IIS)

## Referring Healthcare Professional Information:

Signature: _____

Name: _____

Practice: _____

Phone Number: _____

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