



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)
- 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: _____

