Zoster (shingles)

Date Given	Product*	Physician/Clinic

Other Vaccines

Vaccine	Date Given	Physician/Clinic	Next Due Date

Tuberculosis (TB) Test

Date Given	Physician/Clinic	TST or QFT-G	Results

Influenza (nasal spray or injectable)

Date Given	Product*	Physician/Clinic	Next Due Date

More information

Washington State Department of Health

- *doh.wa.gov/immunization*

School requirements:

- *doh.wa.gov/vaxtoschool.*

Free booklet: *Plain Talk About Childhood Immunization*

- Download: *bit.ly/PlaintalkEng*
- Order: *immunematerials@doh.wa.gov*

Childhood vaccines and well-child visit information:

- Watch Me Grow Washington: *watchmegrowwa.org*

Health and financial resources for your family:

- Help Me Grow Washington Hotline: 1-800-322-2588

U.S. Centers for Disease Control and Prevention

- *cdc.gov/vaccines*
- Phone: 1-800-232-4636 | TTY: 1-888-232-6348

Ask your doctor or clinic to be sure the immunizations in this record are entered into the Washington State Immunization Information System. You may need your immunization record for child care, school, camp, college, the military, travel, employment, or long-term care.
Sign up to get access to your and/or your family's official immunization records online at *myirmobile.com.*
Talk to your doctor or clinic about your immunization questions or visit the Washington State Department of Health at *doh.wa.gov/immunization.*

To request this document in another format, call 1-800-525-0127.
Deaf or hard of hearing customers needing assistance, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

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Lifetime Immunization Record

THE SEAL OF THE STATE OF WASHINGTON 1889

Name:______________________________

Birth Date:__________________________

Allergies/Vaccine Reactions:__________________
____
____

Washington State Department of HEALTH

WASHINGTON STATE IMMUNIZATION INFORMATION SYSTEM

Bring this record to every visit with your doctor or nurse and ask for a signature or clinic stamp.

Hepatitis B Immune Globulin (HBIG)

Date Given	Hospital/Physician/Clinic

Hepatitis B (HepB) Use lines on back under Other Vaccines if needed.

Dose #	Date Given	Product*	Physician/Clinic	Next Due Date
1				
2				
3				

Rotavirus (RV)

Dose #	Date Given	Product*	Physician/Clinic	Next Due Date
1				
2				
3				

Diphtheria, Tetanus, Pertussis (DTaP, DT)

Dose #	Date Given	DTaP	DT	Physician/Clinic	Next Due Date
1					
2					
3					
4					
5					

Haemophilus influenzae type b (Hib)

Dose #	Date Given	Product*	Physician/Clinic	Next Due Date
1				
2				
3				
4				

Pneumococcal (PCV, PPSV)

Dose #	Date Given	PCV	PPSV	Physician/Clinic	Next Due Date
1					
2					
3					
4					

Polio (IPV, OPV)

Dose #	Date Given	IPV	OPV	Physician/Clinic	Next Due Date
1					
2					
3					
4					

Measles, Mumps, Rubella (MMR)

Dose #	Date Given	Product*	Physician/Clinic	Next Due Date
1				
2				

Chickenpox (Varicella)

Dose #	Date Given	Product*	Physician/Clinic	Next Due Date
1				
2				

o Date of chickenpox infection_____

o Provider signature_____

Hepatitis A (HepA)

Dose #	Date Given	Product*	Physician/Clinic	Next Due Date
1				
2				

*Use the Product column to write the name of the vaccine. Record combination vaccines in the section for each individual component. For example, record each component of the Pediarix vaccine: HepB, DTaP, and IPV. **If you need more room to record vaccine doses, use the lines on the back under the Other Vaccines section.**

Meningococcal

Dose #	Date Given	MenACWY	MenB	Physician/Clinic	Next Due Date
1					
2					
3					

Human Papillomavirus (HPV)

Dose #	Date Given	Product*	Physician/Clinic	Next Due Date
1				
2				
3				

Tetanus, Diphtheria, Pertussis Booster (Tdap,Td)

Date Given	Tdap	Td	Physician/Clinic	Next Due Date