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								

Influenz	a (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/SCCI

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 wa.myir.net.

Talk to your doctor or clinic about your immunization questions or visit the Washington State Department of

request this document in another format, call 1-800-525-0127.	
eaf or hard of hearing customers needing assistance, please call 711 (V	Nashingto
alay) or amail civil rights@doh wa gov	_

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Health at doh.wa.gov/immunization.

325-0073E DOH 348-001

001 February 2022

Lifetime Immunization Record



Name:
Birth Date:
Allergies/Vaccine Reactions:
, morgross, vaccine reactioner.





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

Hepatitis B Immune Globulin (HBIG)					Haemophilus influenzae type b (Hib)						Measles, Mumps, Rubella (MMR)				Meningococcal						
Date G	iven		Hospital,	/Physician/Clinic		Dose #	Date Giv	en Pro	duct*	Physician/Clinic	Next Due Date	Dose Date Given	Product*	Physician/Clinic	Next Due Date	Dose #	Date Given	MenACWY	MenB	Physician/Clinic	Next Due Date
	5 (1						1				1					
	atitis B (F	H epB) ∪s	e lines on	back under Other Vaccine		2						2				2					
Dose #	Date Given	Produ	ıct*	Physician/Clinic	Next Due Date	3										3					
1						4															
2																Hun	nan Papi	llomav	irus (HPV)	
3						D		ccal (P			Novt Duo	Chickenpox	(Varicella)				Date Given			Physician/Clinic	Next Due Date
	. (D)	/\				Dose #	Date Giv	en PCV	PPSV	Physician/Clinic	Next Due Date	Dose Date Given	Product*	Physician/Clinic	Next Due Date	1					Date
	virus (R\				Next Due	1						1				2					
Dose #	Date Given	Produ	ct*	Physician/Clinic	Date	2						2				3					
1						3															
2						4						o Date of chicker o Provider signat	•			Teta	nus, Dip	htheria	a, Per	tussis Booster (Tdap,Td)
3															_	Date (Given Tdap	Td Physician/Clinic			Next Due Date
												Hepatitis A (Next Due						
	theria, T	etanus,	Pertu	ssis (DTaP, DT)			o (IPV,				Next Due	Dose # Date Given	Product*	Physician/Clinic	Date						
Dose #	Date Given	DTaP	DT	Physician/Clinic	Next Due Date	Dose #	Date Giv	en IPV	OPV	Physician/Clinic	Date	1									
1						1						2									
2						2															
3						3						*Use the Product column to write the name of the vaccine. Record									
4						4						combination vaccines in the section for each individual component. For example, record each component of the Pediarix vaccine: HepB,									
5												DTaP, and IPV. If you need more room to record vaccine doses use the lines on the back under the Other Vaccines section.									
												use the lines on	the back unde	er the Other Vaccin	es section.						