Notification of Vaccination Letter Template

Dear doctor or nurse 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/YY)
(For a child, parent/guardian name ___________________________ Parent/guardian birthdate ______________ (MM/DD/YY))

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

VACCINES ADMINISTERED

COVID-19
☐ mRNA (circle one): Moderna   Pfizer
☐ viral vector ([Janssen [Johnson & Johnson]])

Hepatitis B
☐ Engerix-B, Recombivax HB
☐ Heplisav-B (age 18 yrs and older)
☐ DTaP (age 6 yrs and younger)
☐ DTaP-HepB-IPV (Pediarix)
☐ DTaP-IPV (Kinrix, Quadracel)
☐ DTaP-IPV/Hib (Pentacel)
☐ DTaP-IPV-Hib-HepB (Vaxelis)
☐ DT (through age 6 yrs)
☐ Tdap (age 7 yrs and older)
☐ Td (age 7 yrs and older)

Hib (monovalent)
☐ ActHIB (PRP-T)
☐ Hiberix (PRP-T)
☐ PedvaxHIB (PRP-OMP)
☐ Influenza
☐ Influenza
☐ IPV (Polio)
☐ Pneumococcal conjugate (PCV13) (Prevnar 13)
☐ Pneumococcal polysaccharide (PPSV23) (Pneumovax 23)

Rotavirus
☐ RV1 (Rotarix)
☐ RV5 (RotaTeq)

☐ Human papillomavirus (9vHPV) (Gardasil 9)
☐ MMR
☐ Varicella (chickenpox) (Varivax)
☐ MMRV (ProQuad)
☐ Hepatitis A (Havrix; Vaqta)
☐ HepA-HepB (Twinrix)
☐ Meningococcal ACWY (MenACWY) (circle one): (Menactra, MenQuadfi, Menveo)
☐ Meningococcal B (MenB)
☐ Bexsero (MenB-4C)
☐ Trumenba (MenB-FHbp)
☐ Zoster (shingles) (RZV) (Shingrix)
☐ Other ______________________________

NAME OF CLINIC PROVIDING SERVICES ___________________________
ADDRESS ___________________________
CITY/STATE/ZIP ___________________________

CLINIC CONTACT PERSON ___________________________
EMAIL ADDRESS ___________________________
PHONE ___________________________

Immunization Action Coalition
Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org
www.immunize.org/catg.d/p3060.pdf • Item #P3060 (6/21)