# Child and Teen Immunization Record

**Immunization Action Coalition**  
Saint Paul, Minn.  
www.immunize.org

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Item #R2003 (12/19)

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**Last name**  
**First name**  
**M.I.**

**Birthdate:**

<table>
<thead>
<tr>
<th>Patient Number:</th>
<th>Medical notes (e.g., allergies, vaccine reactions):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare professional or clinic name</td>
<td>Date next dose due</td>
</tr>
</tbody>
</table>

To learn more about vaccines, visit www.vaccineinformation.org and www.immunize.org

<table>
<thead>
<tr>
<th>Vaccine Type of vaccine</th>
<th>Date given</th>
<th>Healthcare professional or clinic name</th>
<th>Date next dose due</th>
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</thead>
<tbody>
<tr>
<td>Influenza</td>
<td>IIV, RIV, LAIV</td>
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<tr>
<td>Diphtheria, Pertussis (whooping cough)</td>
<td>DTaP, DTP, DT</td>
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<td>Hepatitis B</td>
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