	Vaccine Type (circle specific type given)	Date Given	Doctor or Clinic	Date Next Due
1	*Hep B			
2	*Hep B			
3	*Hep B			
1	*Hep A			
2	*Hep A			
3	*Hep A			
1	*Meningococcal			
Other				

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1	Varicella			
2	Varicella			
1	Zoster			
1	HPV			
2	HPV			
3	HPV			
1	MMR			
2	MMR			
1	Pneumococcal			
Other				

* If medically indicated.

Please fold on dotted line

Florida HEALTH

Division of Disease Control & Health Protection

Immunization Section

850-245-4342

www.ImmunizeFlorida.org

Name _____

(Last, First, MI)

Telephone _____

Address _____

_____

Medical Notes _____

_____

_____

Vaccine Type (circle specific type given)		Date Given	Doctor or Clinic	Date Next Due
1	Tdap			
1	Td every 10 years			
2	Td			
3	Td			
4	Td			
5	Td			
6	Td			
7	Td			

1	†Flu (IIV/LAIV)			
2	†Flu (IIV/LAIV)			
3	†Flu (IIV/LAIV)			
4	†Flu (IIV/LAIV)			
5	†Flu (IIV/LAIV)			
6	†Flu (IIV/LAIV)			
7	†Flu (IIV/LAIV)			
8	†Flu (IIV/LAIV)			
9	†Flu (IIV/LAIV)			
10	†Flu (IIV/LAIV)			
11	†Flu (IIV/LAIV)			

Other				
Other				
Other				
Other				
Other				
Other				
Other				
Other				
Other				
Other				

†Seasonal