

Resident Immunization Record

Name _____ Date of Birth _____

Resident's Identification Number _____ Sex: ___ F ___ M

Record of Immunizations Prior to Admission

Does this person have evidence of immunization for:

1. Pneumococcal Vaccine (Pneumovax 23, Pnu-Imune 23)? Yes No

Approximate date of immunization: _____

Location of immunization (e.g. hospital, physician office): _____

Where there is no documentation, or if evidence of immunization is uncertain, offer the immunization with appropriate counseling and consent. If the immunization is refused, document refusal at admission and offer again at a later time.

2. Tetanus-diphtheria (Td) toxoid during the past 10 years? Yes No

Approximate date of immunization: _____

Location of immunization (e.g. hospital, physician office): _____

3. During the months of November through January, does the new arrival have evidence of an influenza vaccination for the current season? Yes No

Approximate date of immunization: _____

Location of immunization (e.g. hospital, physician office): _____

DO NOT REMOVE FROM CHART

Immunizations Administered Upon Admission

Note: Immunization consent forms should be completed by the resident or responsible party upon admission to the facility.

Vaccine	Trade Name or Manufacturer	Date Received	Injection Site	Vaccine Lot Number	Adverse reactions (0-72 hrs.)	Administered by (Initial.)
Influenza						
Pneumococcal						
Td						

Immunizations Administered While Residing in the Facility

Vaccine	Trade Name or Manufacturer	Date Received	Injection Site	Vaccine Lot Number	Adverse reactions (0-72 hrs.)	Administered by (Initial.)
Td						
Pneumococcal						
Pneumococcal						
Influenza						
Influenza						
Influenza						
Influenza						
Influenza						

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