IMMUNIZATIONS					
Vaccine	***Vaccine Type***	***Date Given***			***Doctor/Clinic/Source***
		Mo	***Day***	***Yr***	
Diphtheria, Tetanus, Pertussis *DTaP/DTP/DT/ Td/Tdap*					
Polio *IPV/OPV*					
Measles, Mumps, Rubella *MMR*					
Haemophilus influenzae type b *Hib*					
Hepatitis B					
Varicella *Chickenpox*					
Pneumococcal *PCV/PPV*					

IMMUNIZATIONS					
Vaccine	***Vaccine Type***	***Date Given***			***Doctor/Clinic/Source***
		Mo	***Day***	***Yr***	
Meningococcal *MCV4/MPSV4*					
Hepatitis A					
Rotavirus					
HPV					
Influenza					
Other					

State of Iowa

Immunization Record

_____

Name & Date of Birth

_____

Doctor's Name & Phone Number

Important: Maintain immunization records in a safe place. Proof of immunizations may be necessary throughout your life.

IMMUNIZE FOR A

Better Life