



H1N1 INFLUENZA VACCINE RECORD

Information About Person To Receive Vaccine (Please Print)

_____	_____	_____
Last Name	First Name	Date of Birth
_____		_____
Mailing Address		Apt/Suite
_____	_____	_____
City	State	Zip
_____	_____	_____
Area Code	Phone Number	Parent/Guardian Name

For Clinic Use Only

Vaccination Date: _____

Date of VIS : _____

Dosage Volume: _____

Signature of Vaccine Administrator

Admin. Site: Right Deltoid
 Left Deltoid
 Intra Nasal

Lot Number: _____

Manufacturer: _____

Signature Date