ARIZONA DEPARTMENT
OF HEALTH SERVICES

Adult Immunization Administration Record

Practice Name: _____

Address: _____

Patient Name: _____ **Birth Date:** _____ ◯M ◯F

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Parent, Guardian, or vaccine recipient - Please read and initial.

Initials	
	Statement 1: I have read or have had explained to me the information contained in the Vaccine Information Statements (VISs) about the following disease(s) and vaccine(s): Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella singly or in combination, Hepatitis A, Hepatitis B, Varicella, Pneumococcal, Meningococcal, Human Papilloma Virus, Herpes Zoster, and Influenza. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated on this form be given to me or the person named on this health record for who I am authorized to make this request.
	Statement 2: I agree to allow the health care provider giving vaccinations to release information about all vaccinations given to me, or to the person for whom I am authorized to consent, to the Arizona State Immunization Information System (ASIIS), other health care providers and schools in order to avoid receiving unnecessary vaccinations and to provide information about what immunizations have been received. I understand that I am not required to agree to the release of this information in order to receive the vaccinations I request.
	If I do not wish this record to be included in ASIIS, I have the option of crossing out the above boxed statement and initialing it. I understand that by making this decision, I will not have access to my immunization records (in ASIIS) in the future for schools, college attendance, future jobs/employment, military, etc.

TB Test	Date Given	Provider Signature	Date Read	Result	TB Test	Date Given	Provider Signature	Date Read	Result

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Patient's Name:	Date of Birth:	ASIIS#:

Vaccine	Date Vax & VIS Given	Signature of Person to receive vaccine or person authorized to make request**	Vaccine Manufacturer	Vaccine Lot Number	Enter site used, i.e. LD, RD, LSC, RVL, oral or nasal etc.	Name/Title of Vaccine Administrator	Date of VIS
Please Include Date and Provider of Previous (historical) Immunizations							
Td/Tdap (circle)							
Td/Tdap (circle)							
Td/Tdap (circle)							
MMR 1							
MMR 2							
Varicella 1							
Varicella 2							
HPV 1							
HPV 2							
HPV 3							
HZV (Zostavax) *prior to 11/2020*							
HZV Shingrix 1							
HZV Shingrix 2							
PCV___ *(Fill in Type)* **1**							
PCV___ (Fill in Type) **2**							
PPSV23 1							
PPSV23 2							
PPSV23 3							
Hep A 1							
Hep A 2							
Hep A 3							
Hep B 1							
Hep B 2							
Hep B 3							
MenACWY 1							
MenACWY 2							
Men B 1							
Men B 2							
Men B 3							
RSV							
COVID							
Other Immunizations							