**BALTIMORE'S IMMUNIZATION REGISTRY PROGRAM**
**VACCINE ADMINISTRATION ENTRY FORM**

HEALTH CARE PROVIDER
(CLINIC NAME)

MONTH / YEAR : /

PLEASE CHECK OFF ADMINISTERED VACCINATION(S)

| LAST NAME | FIRST NAME | MI | D.O.B. | MED RECD # | **DTaP** | **DTap-IPV-HepB** | DT | **DTaP-HIB** | Td | **IPV** | **MMR** | **HIB** | **HIB - HepB** | **Hep-B** | **VARICELLA** | **"Prevnar" (PCV-7)** | PNEUMO (PPV-23) | **Hep-A** | INFLUENZA | RSV ("Synagis") | | DOSE DATE | VFC VACCINE | PPD | BLOOD LEAD DRAWN |
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