	Zoster (S	Shing	(les)		
Date Given	Product		Physician/Clinic		
	Other V	acciı	nes		
Date Given	Product Pr		cian/Clinic	Next Due Date	
	<b>Tuberculos</b>	is (T	B) Test		
Date Given	Physician/Clinic		ST or QFT-G	Results	

Influe	nza (N	asal S	pray or Inje	ctable)
Date Given	Prod	duct	Physician/Clinic	Next Due Date
		00)//	D 10	
			D-19	
Date Given	Prod	duct	Physician/Clinic	Next Due Date
		R	SV	
Date Given	Antibody	Vaccine	Physician/Clinic	Next Due Date

## More information

## Washington State Department of Health

doh.wa.gov/immunization

School requirements:

doh.wa.gov/vaxtoschool

Free booklet: Plain Talk About Childhood Immunization

- Download: bit.ly/PlaintalkEng
- Order: immunematerials@doh.wa.gov

Childhood vaccines and well-child visit information:

• Watch Me Grow Washington: watchmegrowwa.org

Health and financial resources for your family:

• Help Me Grow Washington Hotline: 1-800-322-2588

## U.S. Centers for Disease Control and Prevention

- cdc.gov/vaccines
- Phone: 1-800-232-4636 | TTY: 1-888-232-6348

Ask your doctor or clinic to be sure the immunizations in this record are entered into the Washington State Immunization Information System. You may need your immunization record for child care, school, camp, college, the military, travel, employment, or long-term care.

Sign up to get access to your and your family's official immunization records online at myirmobile.com.

Talk to your doctor or clinic about your immunization questions or visit the Washington State Department of Health at doh.wa.gov/immunization.

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email <a href="mailto:doh.information@doh.wa.gov">doh.information@doh.wa.gov</a>.

DOH 348-001 January 2024

## Lifetime Immunization Record



Birth Date:	
Allergies & Vaccine Reactions:	





Bring this record to every visit with your doctor or nurse and ask for a signature or clinic stamp.

	Hepati	tis B	lmn	nune Globulin (H	BIG)		Haem	ophili	ıs Infl	luenzae type B
Da	ite Given			Physician/Clinic		Dose	Date	Pro	duct	Physician/Clinic
						1				
		Не	pati	tis B (HepB)		2				
Dose	Date		duct	Physician/Clinic	Next Due	3				
1					Date	4				
2										
3						Di	phther	ia, Te	etanus	s, Pertussis (Dī
						Dose	Date	DTaP	DT	Physician/Clinic
			Rota	virus (RV)		1				
Dose	Date		duct	Physician/Clinic	Next Due	2				
1	Date	110		T Hydiolary diffic	Date	3				
2						4				
3										
	Pn	eum	000	cal (PCV, PPSV	)				olio (	IPV, OPV)
Dose	Date	PCV	PPSV	Physician/Clinic	Next Due	Dose	Date	IPV	OPV	Physician/Clinic
1	Date	100	1100	1 Hysiciany oninic	Date	1				
2						2				
3						3				
4						4				
-										

_		_	, Rubella (MMI	Next D
Dose	Date	Product	Physician/Clinic	Date
1				
2				
	C	Chickenpox	(Varicella)	
Dose	Date	Product	Physician/Clinic	Next Double
1				
2				
Date o	of Chickenpo	x Infection:		
	er Signature			
		Hepatitis	A (HepA)	
Dose	Date	Product	Physician/Clinic	Next Double
1				

Next Due Date

Next Due Date

Next Due Date

**Note:** Use the Product column to write the name of the vaccine. Record combination vaccines in the section for each individual component. For example, record each component of the Pediarix vaccine in the HepB, DTaP, and IPV sections. **If you need more room for vaccine doses, use the lines available on the Other Vaccines section.** 

Dose	ate	MenACWY	MenB	enACWY, Mer  Physician/Clinic	Next Due Date
1					2000
2					
3					
	Hu	man Pa	apillon	navirus (HPV)	
Dose	ate	Product		Physician/Clinic	Next Due Date
1					
2					
3					_
Tei Date	Tdap	<b>Diphth</b> Td		ertussis (Tda vsician/Clinic	Next Due