



State of Rhode Island Adult Vaccine Administrator Record

Practice Name and Address:

Patient Name: _____

Date of Birth ___/___/___ Record Number _____

Vaccine Type	Date given: mm/dd/yyyy	Site: RA/LA RT/LT	Vaccine		Vaccine Information Statement (VIS)		Signature or Initials of Vaccinator
			Lot #	Mfr.	Date on VIS	Date VIS given	
Tetanus, diphtheria, pertussis (Tdap) or Tetanus, Diphtheria (Td) • Give IM							
Human Papillomavirus (HPV) • Give IM							
Measles, Mumps, Rubella (MMR) • Give SC or IM							
Varicella (VAR) • Give SC or IM							
Pneumococcal Conjugate • Give IM							
Hepatitis B (Hep B) • Give IM							
Hepatitis A (Hep A) • Give IM							
Meningococcal ACWY Conjugate (MCV4) • Give IM							
Meningococcal B (MenB) • Give IM							
Influenza • <u>TIV</u> : Give IM • <u>LAIV</u> : Give Intranasally							
Zoster (HZV): Give IM							
COVID-19: Give IM							
Mpox • Give ID or SC							
RSV (maternal): Give IM							
RSV (older adults): Give IM							
Other: _____							
TB Test Date: ___/___/___							
Results: _____							