THE BAY CLINIC, INC.
NETWORK OF FAMILY HEALTH CENTERS

VACCINE ADMINISTRATION RECORD

Name: ____ **Birthdate:** ____________________
(First, MI, Last) (MM/DD/YY)

Address: ____ **Phone:** ______________________

Consent: I have read the information provided regarding the ____ Vaccine and have had an opportunity to ask questions. I understand the benefits and risks of the vaccination as described. I request that the vaccine be given to me or the person named above for whom I am authorized to sign.

____ ____________________________
Signature of the person to receive vaccine or parent or guardian **Date**

Vaccine	Date Given (MM/DD/YY)	Dose	Route/Site*	Vaccine Manufacturer	Vaccine Lot Number	Vaccine Information Publication Date
PFIZER		0.3ML		PFIZER	Expiration Date: _________	
Vaccine	Date Given (MM/DD/YY)	Dose	Route/Site*	Vaccine Manufacturer	Vaccine Lot Number Expiration Date: _________	Vaccine Information Publication Date
Vaccine	Date Given (MM/DD/YY)	Dose	Route/Site*	Vaccine Manufacturer	Vaccine Lot Number Expiration Date: _________	Vaccine Information Publication Date
Vaccine	Date Given (MM/DD/YY)	Dose	Route/Site*	Vaccine Manufacturer	Vaccine Lot Number Expiration Date: _________	Vaccine Information Publication Date
Vaccine	Date Given (MM/DD/YY)	Dose	Route/Site*	Vaccine Manufacturer	Vaccine Lot Number Expiration Date: _________	Vaccine Information Publication Date

***Site Legend:** **RA = Right Arm** **LA = Left Arm** **RT = Right Thigh** **LT = Left Thigh**

______________________________ ______________________________ ________________
Signature of Vaccine Administrator **Health Center** **Date**