



VACCINE ADMINISTRATION RECORD

Name: _____

Birthdate: _____

Initial Tuberculosis (TB) Clearance	Test Date		Lot Number		Date Read		Reading (mm) 10mm or > require CXR	MD/ APRN or RN Signature
	Step #1	Step #2	Step #1	Step #2	Step #1	Step #2		
PPD (Mantoux)								

CHEST x-Ray (CXR) - Must Attach copy of an official Radiology Chest X-ray Report and/or clearance from the State of Hawaii, Department of Health, Tuberculosis Branch.

Annual Tuberculosis (TB) Clearance	Test Date	Lot Number	Date Read	Reading (mm) 10mm or > require CXR	MD/ APRN or RN Signature

Initial Vaccine	Date Given (mo/day/yr)	Source (F, S, P)	Site	Vaccine		Vaccine Information Statement		Signature/ Initial of Vaccinator	
				Lot #	Mfr.	Date on VIS	Date Given		
Pneumoccal									
Influenza									
Haemophilus Influenzae Type B									

Annual Vaccine	Date Given (mo/day/yr)	Source (F, S, P)	Site	Vaccine		Vaccine Information Statement		Signature/ Initial of Vaccinator	
				Lot #	Mfr.	Date on VIS	Date Given		