

## **VACCINATION STATUS**

### **ADOLESCENT**

If you turned or will be turning 13 years old this calendar year, please indicate if you had or didn't have each of the following vaccinations:

	<u>YES</u>	<u>NO</u>
1.) Meningococcal (at least age 11)	<input type="checkbox"/>	<input type="checkbox"/>
2.) DPT (at least age 10)	<input type="checkbox"/>	<input type="checkbox"/>
3.) HPV (2 doses) (at least age 9)	<input type="checkbox"/>	<input type="checkbox"/>

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### **ADULT**

If you are 19 years old or older, please indicate if you had or didn't have each of the following vaccinations:

	<u>YES</u>	<u>NO</u>
1.) Flu vaccine (ON or AFTER July of previous year)	<input type="checkbox"/>	<input type="checkbox"/>
2.) Tetanus (within last 10 years)	<input type="checkbox"/>	<input type="checkbox"/>
3.) Zoster (Shingles) (on or after 50 <sup>th</sup> birthday) Live (one dose) OR Recombinant (2 doses)	<input type="checkbox"/>	<input type="checkbox"/>
4.) Pneumococcal vaccine (any) (on or after 60 <sup>th</sup> birthday)	<input type="checkbox"/>	<input type="checkbox"/>

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PRINT PATIENT NAME

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SIGNATURE (patient or legal guardian, if under 18)

\_\_\_\_\_  
DATE