

Notification of Vaccination Letter

Dear Doctor or Nurse at _____ :
Patient's primary care clinic

We have recently provided vaccination services to one of your patients. A personal immunization record card was filled out and given to the patient. We want to make certain that you, too, have this information so that you can update your patient's medical record. Please contact us if you have any questions about this information.

Patient's name: _____ Patient's birthdate: _____

(For a child, parent's name: _____ Parent's birthdate: _____)

The vaccines that were given on _____ are checked below.
Date

Lot Number: _____ Injection Site: _____

Vaccine	Vaccine
<input type="checkbox"/> Hepatitis B (___ mL) <input type="checkbox"/> DTaP <input type="checkbox"/> DTaP-HepB-IPV (Pediarix) <input type="checkbox"/> DTaP-Hib (Trihibit) <input type="checkbox"/> DT <input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> Hib <input type="checkbox"/> Hib-HepB (Comvax) <input type="checkbox"/> Pneumococcal conjugate (PCV) <input type="checkbox"/> Pneumococcal polysaccharide (PPV) <input type="checkbox"/> IPV (Polio)	<input type="checkbox"/> Rotavirus <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> MMRV (ProQuad) <input type="checkbox"/> Hepatitis A <input type="checkbox"/> HepA-HepB (Twinrix) <input type="checkbox"/> Human papillomavirus (HPV) <input type="checkbox"/> Meningococcal conjugate (MCV4) <input type="checkbox"/> Meningococcal polysaccharide (MPSV4) <input type="checkbox"/> Influenza (injectable) <input type="checkbox"/> Influenza (intranasal) <input type="checkbox"/> Zoster (shingles) <input type="checkbox"/> Other _____

Name of clinic providing services	Address	City, State, Zip
Contact Person	Email address	Phone number

www.immunize.org/catg.d/3060not.pdf Item #P3060 (10/06)