ADULT VACCINE ADMINISTRATION RECORD

Randolph Township Department of Health
502 Millbrook Ave., Randolph, NJ 07869
Phone: 973-537-7118 Fax: 973-366-2426

Pay status	Staff Check
Employee	
Insured	
317 Funds	
NJIIS #	

Patient Name _____ _____
_____

Address _____ _____

Town _____ _____**State**_____ **Zip** _____ **Ethnicity:**
Hispanic_____**Not Hispanic**_____

Phone# _____ _____ **Date of Birth** _____

Race:_____

Insurance Company:_____ _____ **Gender: Male**
_____ **Female**_____

Member ID_____ **Group ID**_____ **Medicare ID #**
(MBI)_____ _____

Relationship to Insured_____ **Insured Name**_____ **Insured Date of Birth**_____

I have been provided a copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Materials and have read, or have had explained to me, information about the diseases and vaccines listed below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the risks and benefits of the vaccines cited, and ask that the vaccine(s) listed below be given to me or to the person named above for whom I am authorized to make this request.

SIGNATURE

Vaccine	Date	age	site ***	source (FSP) **	vaccine manu	Vaccine lot number	VIS date pub	VIS date given	Ins Y/N	Plan A Verified A/I	Preg Y/N LMP	IllnesY/N	previous problemY/N	Blood Prod Y/N	Staff Initial *	Client initials
Covid							10/17/24									
Flu							1/31/25									
Hep A 1							1/31/25									
Hep A 2							1/31/25									
Hep B 1							1/31/25									
Hep B 2							1/31/25									
Hep B 3							1/31/25									
HPV 1							8/6/21									
HPV 2							8/6/21									
HPV 3							8/6/21									
MMR 1							1/31/25									
MMR 2							1/31/25									
Men-ACWY							1/31/25									
Men B 1							1/31/25									
Men B 2							1/31/25									
Pneumo 20							5/29/25									
RSV Recomb							1/31/25									
Td							8/6/21									
Tdap							1/31/25									
Varicella 1							1/31/25									

Varicella 2							1/31/25									
Zoster Recomb 1							2/4/22									
Zoster Recomb 2							2/4/22									

Vaccine Admin. Signature_____ Initials_____ * Client Signature_____ Initials_____ *

Vaccine Admin. Signature_____ Initials_____ * Vaccine Admin. Signature_____ Initials_____ *

* Kathy Maher, FNP-C ** F= Federal S=State P=Private *** RA= right arm LA= left arm RT=right thigh LT= left thigh