DO NOT PURGE

S.C. Department of Disabilities and Special Needs
Immunization Record

Name: _____ Date of Birth: _____

ID #: _____ Allergies: _____

Regional Center: ☐Coastal ☐Midlands ☐Pee Dee ☐Whitten

Vaccine and Route	Date	Dose	Site	Manufacturer	Lot #	Expiration Date	Nurse's Name and Signature	V.I.S. Given: Yes/No
DTP/DTaP/DT/Td-1 (IM)								☐yes ☐no
DTP/DTaP/DT/Td-2 (IM)								☐yes ☐no
DTP/DTaP/DT/Td-3 (IM)								☐yes ☐no
DTP/DTaP/DT/Td-4 (IM)								☐yes ☐no
DTP/DTaP/DT/Td-5 (IM)								☐yes ☐no
Td Booster (IM)								☐yes ☐no
Td Booster (IM)								☐yes ☐no
Hepatitis B-1 (IM)								☐yes ☐no
Hepatitis B-2 (IM)								☐yes ☐no
Hepatitis B-3 (IM)								☐yes ☐no
Hepatitis A-1 (IM)								☐yes ☐no
Hepatitis A-2 (IM)								☐yes ☐no
MMR-1 (IM)								☐yes ☐no
MMR-2 (IM)								☐yes ☐no
Varicella - 1 (IM)								☐yes ☐no
Varicella - 2 (IM)								☐yes ☐no
Pneumococcal (IM or SQ)								☐yes ☐no
Pneumococcal (IM or SQ)								☐yes ☐no

Vaccine and Route	Date	Dose	Site	Manufacturer	Lot #	Expiration Date	Nurse's Name and Signature	V.I.S. Given: Yes/No
Polio 1 IPV								☐yes ☐no
Polio 2 IPV								☐yes ☐no
Polio 3 IPV								☐yes ☐no
Polio 4 IPV								☐yes ☐no
Hib 1 (IM)								☐yes ☐no
Hib 2 (IM)								☐yes ☐no
Hib 3 (IM)								☐yes ☐no
Hib 4 (IM)								☐yes ☐no
Influenza (IM)								☐yes ☐no
Influenza (IM)								☐yes ☐no
Influenza (IM)								☐yes ☐no
Influenza (IM)								☐yes ☐no
Influenza (IM)								☐yes ☐no
Influenza (IM)								☐yes ☐no
Influenza (IM)								☐yes ☐no
Influenza (IM)								☐yes ☐no
Influenza (IM)								☐yes ☐no
Influenza (IM)								☐yes ☐no

Date Given	Site	Date Read	Results (mm)	Manufacturer	Lot #	Expiration Date	Nurse's Name and Signature