DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE ASSURANCE

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
PPD (Mantoux)					

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

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