Notification of Vaccination Letter Template

Dear doctor or nurse at _____
PATIENT'S PRIMARY CARE CLINIC

We recently provided vaccination services to your patient. We want to make certain that you have information about the vaccines we administered so you can update your patient's medical record. Please contact us if you have any questions about this information.

☐ We provided the patient (or parent/guardian) with a written record of the vaccination(s) given.

☐ We entered information about the vaccine(s) we administered in the regional or state immunization information system.

Patient's name _____ Patient's birthdate _____
(MM/DD/YR)

(For a child, parent/guardian name _____ Parent/guardian birthdate _____)
(MM/DD/YR)

The vaccine(s) we administered on _____ is/are checked below.
DATE

VACCINES ADMINISTERED

COVID-19
- ☐ mRNA (circle one): Moderna Pfizer
- ☐ viral vector (Janssen [Johnson & Johnson])

Hepatitis B
- ☐ Engerix-B, Recombivax HB
  DOSE (circle one): 0.5 mL 1.0 mL
- ☐ Heplisav-B (age 18 yrs and older)

☐ DTaP (age 6 yrs and younger)

☐ DTaP-HepB-IPV (Pediarix)

☐ DTaP-IPV (Kinrix, Quadracel)

☐ DTaP-IPV/Hib (Pentacel)

☐ DTaP-IPV-Hib-HepB (Vaxelis)

☐ DT (through age 6 yrs)

☐ Tdap (age 7 yrs and older)

☐ Td (age 7 yrs and older)

Hib (monovalent)
- ☐ ActHIB (PRP-T)
- ☐ Hiberix (PRP-T)
- ☐ PedvaxHIB (PRP-OMP)

☐ Influenza
  BRAND _____
  DOSE (mL) _____
  ROUTE (circle one): IM Nasal

☐ IPV (Polio)

☐ Pneumococcal conjugate (PCV13) (Prevnar 13)

☐ Pneumococcal polysaccharide (PPSV23) (Pneumovax 23)

Rotavirus
- ☐ RV1 (Rotarix)
- ☐ RV5 (RotaTeq)

☐ Human papillomavirus (9vHPV) (Gardasil 9)

☐ MMR

☐ Varicella (chickenpox) (Varivax)

☐ MMRV (ProQuad)

☐ Hepatitis A (Havrix; Vaqta)
  DOSE (circle one): 0.5 mL 1.0 mL

☐ HepA-HepB (Twinrix)

☐ Meningococcal ACWY (MenACWY) (circle one): (Menactra, MenQuadfi, Menveo)

Meningococcal B (MenB)
- ☐ Bexsero (MenB-4C)
- ☐ Trumenba (MenB-FHbp)

☐ Zoster (shingles) (RZV) (Shingrix)

☐ Other _____

_____ NAME OF CLINIC PROVIDING SERVICES

_____ CLINIC CONTACT PERSON

_____ ADDRESS

_____ EMAIL ADDRESS

_____ CITY/STATE/ZIP

_____ PHONE

IMMUNIZATION ACTION COALITION Saint Paul, Minnesota ▪ 651-647-9009 ▪ www.immunize.org ▪ www.vaccineinformation.org
www.immunize.org/catg.d/p3060.pdf ▪ Item #P3060 (6/21)