AFFILIATED PHYSICIANS
ON-SITE VACCINATION AND WELLNESS SERVICES

Certificate of Immunization

Provide a copy of the following information to your medical provider.

The person below received a vaccine today.

Patient Name: ________________________________**Date of Birth:** ☐☐/☐☐/☐☐☐☐

Patient Preferred Name: ___________________________

Patient Signature: ________________________________

Date of vaccine administration: ☐☐/☐☐/☐☐☐☐

☐Adult (> 17 years old) ☐Peds (< 17 years old)

- ☐ Live Monkeypox Vaccine - ☐ SQ 0.5mL ☐ID 0.1mL
- ☐ Influenza Vaccine - IM 0.5mL
- ☐ COVID Vaccine - IM dose _______
- ☐ Tdap Vaccine - IM 0.5mL

Manufacturer:
Lot #:
Expiration:
____

Injection site (*check one*):

☐Arm ☐ Right ☐ Left
☐Thigh ☐ Right ☐ Left
☐Abdomen ☐ Right ☐ Left
☐Back Scapula ☐ Right ☐ Left
☐Forearm ☐ Right ☐ Left
☐Other _______________

☒EUA/VIS Provided - Statement Date:

☐☐/☐☐/☐☐☐☐

Vaccinator's Name (print): ____________________________☐ LPN☐ RN☐ NP☐ PA☐ MD

Clinician Signature:_______________________________________ Date:____________