**Vaccination and Immunization Record Form**

**Personal Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** |  | **Employee / ID No.** |  |
| **Department / Unit** |  | **Date of Birth** |  |
| **Gender** | ☐ Male ☐ Female ☐ Other | **Contact Number** |  |
| **Email Address** |  | **Emergency Contact Name** |  |
| **Emergency Contact Number** |  |  |  |

**Vaccination Record**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Vaccine Name** | **Date Administered (1st Dose)** | **Date Administered (2nd Dose)** | **Booster Date (if any)** | **Administered By (Name/Clinic)** | **Batch / Lot No.** | **Remarks / Side Effects** |
| COVID-19 |  |  |  |  |  |  |
| Hepatitis B |  |  |  |  |  |  |
| Influenza (Flu) |  |  |  |  |  |  |
| Tetanus (Td/Tdap) |  |  |  |  |  |  |
| Measles, Mumps, Rubella (MMR) |  |  |  |  |  |  |
| Polio (IPV) |  |  |  |  |  |  |
| Typhoid |  |  |  |  |  |  |
| Yellow Fever |  |  |  |  |  |  |
| Varicella (Chickenpox) |  |  |  |  |  |  |
| Others (Specify): |  |  |  |  |  |  |

**Summary**

|  |  |  |  |
| --- | --- | --- | --- |
| **Total Vaccines Received** |  | **Next Due Vaccine (if applicable)** |  |
| **Next Due Date** |  |  |  |

**Certification**

I hereby confirm that the above vaccination details are accurate to the best of my knowledge.

**Employee Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Verified By (Health Officer / HR):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notes / Instructions**

* Attach photocopies of vaccination cards or certificates for verification.
* This record should be updated after every new immunization.
* Keep a digital copy for HR or health department records.