

**HEALTH RECORD**

**IMMUNIZATION RECORD**

*All entries in ink to be made in block letter*

**VACCINATION AGAINST SMALLPOX** (Number of previous vaccination scars)

	DATE	ORIGIN	BATCH NUMBER	REACTION	STATION	PHYSICIAN'S NAME
1						
2						
3						
4						
5						
6						

**YELLOW FEVER VACCINE**

	DATE	ORIGIN	BATCH NUMBER	STATION	PHYSICIAN'S NAME
1					
2					
3					

**TYPHOID VACCINE**

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				4			
2				5			
3				6			

**TETANUS-DIPHTHERIA TOXOIDS**

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				4			
2				5			
3				6			

**CHOLERA VACCINE**

	DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME
1			4			7		
2			5			8		
3			6			9		

**PATIENT'S IDENTIFICATION** (Mechanically Imprint, Type or Print):



Patients's Name--last, first, middle initial;  
Sex, Age or Year of Birth; Relationship to Sponsor;  
Component/ Status; Department/ Service.



Sponsor's Name--last, first, middle initial;  
Rank/Grade; SSN or Identification Number;  
Organization.

**IMMUNIZATION RECORD**

Standard Form 601--October 1975 (Rev.)  
General Services Administration & Interagency  
Committee on Medical Records  
FIRMR (4) CFR 201-45.505

**ORAL POLIOVIRUS VACCINE**

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				3			
2				4			

**INFLUENZA VACCINE**

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				3			
2				4			

**OTHER IMMUNIZATIONS**

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				5			
2				6			
3				7			
4				8			

**SENSITIVITY TEST (*Tuberculin, etc.*)**

	DATE	TYPE	DOSE	ROUTE	RESULTS	PHYSICIAN'S NAME
1						
2						
3						
4						
5						

**REMARKS:**