VACCINATION RECORD

Québec

Vaccination,
the best protection

This booklet is an important document.

It is the only record of all the vaccines you have received.
You will need it all your life, so keep it in a safe place and keep it up to date.
Take it with you to each medical appointment.

For optimal protection, it is important to follow the regular vaccination schedule. Make an appointment at the recommended ages to avoid delays.

IDENTIFICATION

Family name:

Given name:

Date of birth: YEAR / MONTH / DAY

Sex: ☐ Male ☐ Female

Health insurance number:

Mother's family name:

Mother's given name:

Father's family name:

Father's given name:

Current telephone number:
(in case booklet is lost)

(USE PENCIL AND CORRECT AS NEEDED)

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BIRTH

Place of birth (locality):		Time:
Name of institution:		
Length of pregnancy:		
Type of delivery: ☐ vaginal ☐ cæserean section		
Birth weight: /g	Blood group:	Apgar score:
Cranial circumference: /cm	Rh factor:	Length: /cm
Initial hearing screening: ☐ Passed ☐ Repeat – Outpatient care ☐ Not done		
Second screening – Outpatient care: ☐ Passed ☐ Passed with monitoring ☐ Audiological evaluation		

GROWTH (observations by health care professional)

Date (year-month-day)	Age	Weight/percentile (in g or kg)	Length/percentile (in cm)	Cranial circumference (in cm)

To be completed by the person administrating the vaccines

Medical information related to vaccination

(e.g. anaphylactic allergy, side effects following vaccination)

Diphtheria (d or D) - Tetanus (T) - Pertussis (whooping cough) (ap or aP) - Hepatitis B (HB) - Poliomyelitis (IPV) - *Hæmophilus influenzæ* type b infections (Hib)

Date (year-month-day)	**Name of vaccine** (print)	**Dose/route of admin.**	**Signature**

Rotavirus gastroenteritis

Date (year-month-day)	Name of vaccine (print)	Dose/route of admin.	Signature

Pneumococcal infections

Date (year-month-day)	Name of vaccine (print)	Dose/route of admin.	Signature

Measles (M) - Mumps (M) - Rubella (German Measles) (R) - Varicella (Var)

Date (year-month-day)	Name of vaccine (print)	Dose/route of admin.	Signature

Meningococcal infections

Date (year-month-day)	Name of vaccine (print)	Dose/route of admin.	Signature

Hepatitis A and Hepatitis B (combined vaccine)

Date (year-month-day)	Name of vaccine (print)	Dose/route of admin.	Signature

Hepatitis A

Date (year-month-day)	Name of vaccine (print)	Dose/route of admin.	Signature

Hepatitis B

Date (year-month-day)	Name of vaccine (print)	Dose/route of admin.	Signature

Human Papillomavirus (HPV)

Date (year-month-day)	Name of vaccine (print)	Dose/route of admin.	Signature

Respiratory viruses (e.g. flu, COVID-19, respiratory syncytial virus)

Date (year-month-day)	Name of vaccine (print)	Dose/route of admin.	Signature

Respiratory viruses (e.g. flu, COVID-19, respiratory syncytial virus)

Date (year-month-day)	Name of vaccine (print)	Dose/route of admin.	Signature

Shingles

Date (year-month-day)	Name of vaccine (print)	Dose/route of admin.	Signature

Tuberculine Skin Test (TST)

Date (year-month-day)	Dose/route of admin.	Signature

Date of reading	Reaction (in mm)	Signature

Date (year-month-day)	Dose/route of admin.	Signature

Date of reading	Reaction (in mm)	Signature

Tuberculine Skin Test (TST)

Date (year-month-day)	Dose/route of admin.	Signature

Date of reading	Reaction (in mm)	Signature

Date (year-month-day)	Dose/route of admin.	Signature

Date of reading	Reaction (in mm)	Signature

Tuberculosis

Date (year-month-day)	Name of vaccine (print)	Dose/route of admin.	Signature

Rabies

Date (year-month-day)	Name of vaccine (print)	Dose/route of admin.	Signature

Rabies

Date (year-month-day)	Name of vaccine (print)	Dose/route of admin.	Signature

Other vaccines

Date (year-month-day)	Name of vaccine (print)	Dose/route of admin.	Signature
	Vaccine against:		
	Vaccine against:		
	Vaccine against:		

Other vaccines

Date (year-month-day)	Name of vaccine (print)	Dose/route of admin.	Signature
	Vaccine against:		
	Vaccine against:		
	Vaccine against:		

Vaccine against:

Vaccine against:

Vaccine against:

Vaccine against:

Other vaccines

Date (year-month-day)	Name of vaccine (print)	Dose/route of admin.	Signature
	Vaccine against:		
	Vaccine against:		
	Vaccine against:		

Immunoglobulins and monoclonal antibodies

Date (year-month-day)	Name of vaccine (print)	Dose/route of admin.	Signature
	Immunoglobulins / monoclonal antibodies against:		
	Immunoglobulins / monoclonal antibodies against:		
	Immunoglobulins / monoclonal antibodies against:		

Travelers (e.g. typhoid, japanese encephalitis)

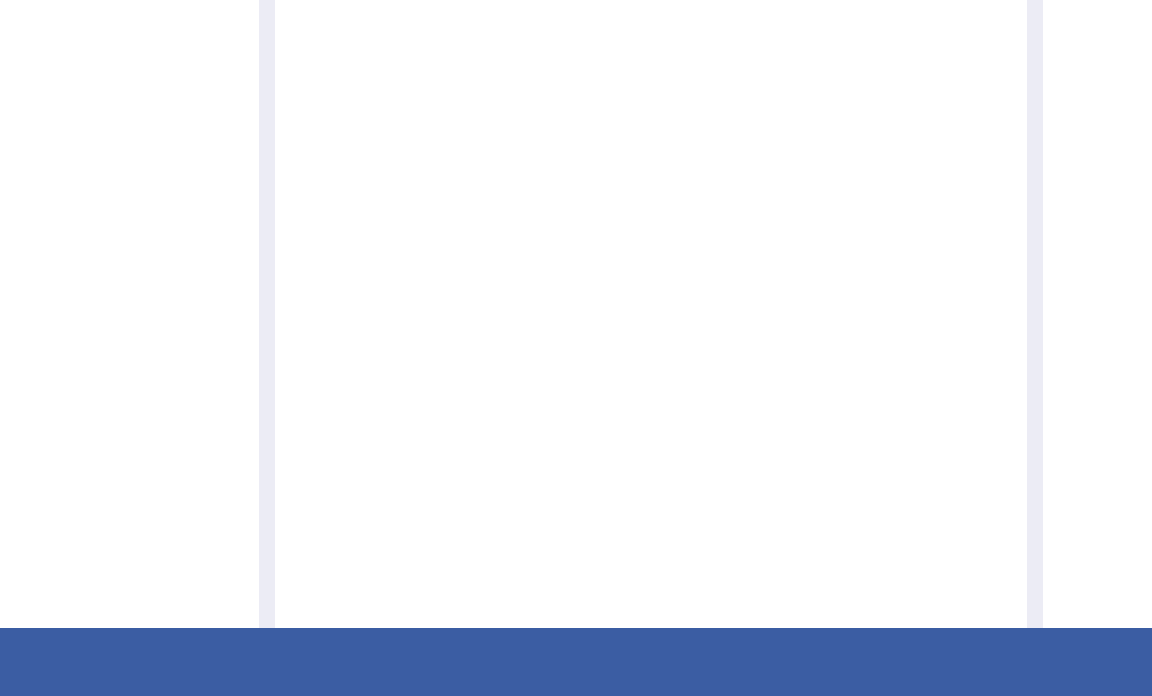
Date (year-month-day)	**Name of vaccine** (print)	**Dose/route of admin.**	**Signature**
	Vaccine against:		
	Vaccine against:		
	Vaccine against:		

Travelers (e.g. typhoid, japanese encephalitis)

Date (year-month-day)	**Name of vaccine** (print)	**Dose/route of admin.**	**Signature**
	Vaccine against:		
	Vaccine against:		
	Vaccine against:		

Yellow fever

Staple International Certificate
of Vaccination or Prophylaxis here



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Santé
et Services sociaux
Québec

KEEP AND TAKE WITH YOU
to each medical appointment.