



**DEPARTMENT OF THE AIR FORCE**

**HEADQUARTERS 913TH AIRLIFT GROUP (AFRC)**

**LITTLE ROCK AIR FORCE BASE, ARKANSAS**

Immunization Transcription Form

Rank and Member Name \_\_\_\_\_ DOD ID# \_\_\_\_\_

Immunization Administered \_\_\_\_\_

Adverse Reaction      Yes \_\_\_\_\_      No \_\_\_\_\_      UNK \_\_\_\_\_

Brief Description of Adverse Reaction

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date Administered \_\_\_\_\_

Location administered (ex. left arm) \_\_\_\_\_

Vaccination Manufacturer \_\_\_\_\_

Lot Number \_\_\_\_\_      Expiration Date \_\_\_\_\_

\_\_\_\_\_  
Medical Provider Signature

\_\_\_\_\_  
Print Name