



Prescriber Name, Address, Phone Number:

Patient Name: _____ Date: _____

Vaccines recommended during pregnancy:

- Tdap** (tetanus, diphtheria, pertussis [whooping cough]) 0.5 mL IM x 1 between 27 and 36 weeks of pregnancy.
- Inactivated Influenza** 0.5 mL IM x 1
- Updated COVID-19 vaccine**
- Respiratory Syncytial Virus (RSV) vaccine (ABRYSVO)** 0.5 mL IM x 1 September-January, between 32 and 36 weeks of pregnancy.

Prescriber's Signature: _____ License #: _____

Per pharmacy regulations (CCR, Title 16, section 1746.4), please notify us within 14 days of administration of the vaccines our patient received at your pharmacy. Also, please give the patient a copy of the vaccine record to bring to their next prenatal visit.

Your baby is counting on you for protection. Get vaccinated.



Prescriber Name, Address, Phone Number:

Patient Name: _____ Date: _____

Vaccines recommended during pregnancy:

- Tdap** (tetanus, diphtheria, pertussis [whooping cough]) 0.5 mL IM x 1 between 27 and 36 weeks of pregnancy.
- Inactivated Influenza** 0.5 mL IM x 1
- Updated COVID-19 vaccine**
- Respiratory Syncytial Virus (RSV) vaccine (ABRYSVO)** 0.5 mL IM x 1 September-January, between 32 and 36 weeks of pregnancy.

Prescriber's Signature: _____ License #: _____

Per pharmacy regulations (CCR, Title 16, section 1746.4), please notify us within 14 days of administration of the vaccines our patient received at your pharmacy. Also, please give the patient a copy of the vaccine record to bring to their next prenatal visit.

Your baby is counting on you for protection. Get vaccinated.



Prescriber Name, Address, Phone Number:

Patient Name: _____ Date: _____

Vaccines recommended during pregnancy:

- Tdap** (tetanus, diphtheria, pertussis [whooping cough]) 0.5 mL IM x 1 between 27 and 36 weeks of pregnancy.
- Inactivated Influenza** 0.5 mL IM x 1
- Updated COVID-19 vaccine**
- Respiratory Syncytial Virus (RSV) vaccine (ABRYSVO)** 0.5 mL IM x 1 September-January, between 32 and 36 weeks of pregnancy.

Prescriber's Signature: _____ License #: _____

Per pharmacy regulations (CCR, Title 16, section 1746.4), please notify us within 14 days of administration of the vaccines our patient received at your pharmacy. Also, please give the patient a copy of the vaccine record to bring to their next prenatal visit.

Your baby is counting on you for protection. Get vaccinated.



Prescriber Name, Address, Phone Number:

Patient Name: _____ Date: _____

Vaccines recommended during pregnancy:

- Tdap** (tetanus, diphtheria, pertussis [whooping cough]) 0.5 mL IM x 1 between 27 and 36 weeks of pregnancy.
- Inactivated Influenza** 0.5 mL IM x 1
- Updated COVID-19 vaccine**
- Respiratory Syncytial Virus (RSV) vaccine (ABRYSVO)** 0.5 mL IM x 1 September-January, between 32 and 36 weeks of pregnancy.

Prescriber's Signature: _____ License #: _____

Per pharmacy regulations (CCR, Title 16, section 1746.4), please notify us within 14 days of administration of the vaccines our patient received at your pharmacy. Also, please give the patient a copy of the vaccine record to bring to their next prenatal visit.

Your baby is counting on you for protection. Get vaccinated.