Immunization Notification Form

Name of Doctor's office: _____

Contact person for clarification if required: _____ **Phone Number:** _____

Date Vaccine(s) Administered (YY-MM-DD)	**Name of client (please print clearly)**		**Clients Health Card Number**	**Date of Birth of client** (YY-MM-DD)	**Gender** (M/F)	RSV	Tdap	Tdap-IPV	RSV		Hepatitis B	HPV	IPV	Meningococcal		MMR	DTaP-IPV-Hib	Pneumococcal	MMR-V	Rotavirus	Zoster	Td	Varicella	Pneumococcal	Examples: Influenza Rabies Act-Hib
	Last Name	First Name				Abrysvo	Adacel / Boostrix	Adacel-Polio / Boostrix-Polio	Beyfortus 50mg	Beyfortus 100mg	Engerix B / Recombivax	Gardasil 9	Imovax Polio	Menjugate / NeisVac-C	Menactra / Nimenrix	MMR II / Priorix	Pediacel / Pentacel	Prevnar -20	Priorix-Tetra / Proquad	Rotarix (RV 1)	Shingrix	Td Adsorbed	Varilrix / Varivax	Vaxneuvance	Other : (Please specify)

FAX FORM WEEKLY TO THE MAIN PHU OFFICE 705-360-7308

Adverse Event Following Immunization (AEFI): Remember to report any AEFI's to the Porcupine Health Unit

Revised: 2024-11-25