Immunization Notification Form

Porcupine Health Unit • Bureau de santé

Name of Doctor's office: _____

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

Immuni3ation

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

PLEASE FAX FORMS WEEKLY TO YOUR LOCAL PORCUPINE HEALTH UNIT to 705-360-7308

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