

Immunization Report Form

| | |
|----------------------------------|---|
| Name: | |
| PHN: | |
| Date of Birth: | yyyy-mm-dd |
| Sex: | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Civic Address: | |
| Date vaccine given: | yyyy-mm-dd |
| Name & Location of Clinic/Office | |
| Comments: | |
| | |
| | |
| | |
| | |
| | |

Check all Products administered during this visit:

| Product Name | Vaccine | Product Name | Vaccine |
|-----------------------|-------------------------------------|----------------------|-------------------------------------|
| Boostrix Polio | DaPTP- Diph,acel Pert,Tet & Polio | Menjugate | Men-C-C-Meningococcal Conjugate C |
| Boostrix | dTap-Diph,Tetanus & acel Pertussis | Nimenrix | Men-P-ACYW-Meningo PolysacchACYW135 |
| Infanrix Hexa | DTap-HB-IPV-Hib | M-M-R II/Priorix | MMR-Measles, Mumps, Rubella |
| Pediacel | DTaP-IPV-Hib | ProQuad | MMRV-Measle,Mumps,Rubella,Varicella |
| VAQT/HAVRIX | Hepatitis A | Pprevnar-13 | Pneumococcal Conjugate 13 |
| Twinrix/Twinrix Jr | Hepatitis A and B | Pneumo-23 | Pneumococcal Polysacch 23 |
| Recombivax HB/Engerix | Hepatitis B | Rabavert | Rabies |
| Hiberix | Hib-Haemophilus influenza type b | Rotarix, Rotateq | Rotavirus |
| Gardasil | HPV-Human Papillomavirus | Td ADSORBED | Td-Tet,Diph-adult |
| Fluzone | Influenza | Varilrix/Varivax III | Varicella |
| High-dose Fluzone-LTC | Influenza | Zostavax/Zostavax II | Shingles |
| Flumist | Influenza | Shingrix | Shingles |
| Menveo | Men-C-ACYW-MeningoConjugate ACYW135 | | |
| | | | |

Please return this form by **fax or mail** to:
 Chief Public Health Office
 PO Box 2000
 Charlottetown, Prince Edward Island C1A
 7N8
 Phone: (902) 368-4996
 Fax: (902) 620-3354