REPORT OF Influenza and COVID-19 Immunizations

By Community Vaccine Provider
Fill in all * *Required fields*
Fax the completed form to Fraser Health at 604-528-5459

* Clinic/Office details Include FULL site details	HEALTH UNIT STAMP
[_____]	

Client #1 - Information

Or place client demographic sticker here

* **Name:**
* **PHN:**
* **Date Of Birth:**
* **Gender:**
* **Address:**
* **Phone:**

Immunization information

* Influenza Vaccine	* Dose (mL)	*Site / *Date / *Time	* Consent	* Immunizer Information
☐ FLULAVAL -Tetra		**Site:** ☐ Arm Left Deltoid - IM ☐ Arm Right Deltoid – IM ☐ Intranasal ☐ Other:	**Provided by:** ☐ **Client** ☐ **Mature Minor** ☐ **Other → Name and relationship to client** ☐ **In Person** ☐ **Phone** ☐ **Written**	**Name:** **Designation:**
☐ FLUMIST Quadrivalent				
☐ FLUZONE Quadrivalent				
☐ FLUAD				
☐ FLUZONE **HD** Quadrivalent		**Date:** **Time:**		
* **Lot Number :**				

* COVID-19 Vaccine	* Dose (mL)	*Site / *Date / *Time	* Consent	* Immunizer Information
☐ **Moderna** (SPIKEVAX) XBB		**Site:** ☐ Arm Left Deltoid - IM ☐ Arm Right Deltoid – IM ☐ Intranasal ☐ Other:	**Provided by:** ☐ **Client** ☐ **Mature Minor** ☐ **Other → Name and relationship to client** ☐ **In Person** ☐ **Phone** ☐ **Written**	**Name:** **Designation:**
Pfizer (Comirnaty) XBB				
☐ **6 mnths to < 5 yrs**				
☐ **5 yrs to < 12 yrs**				
☐ **12 yrs of age +**		**Date:** **Time:**		
* **Lot Number :**				

Client #2 - Information

Or place client demographic sticker here

* **Name:**
* **PHN:**
* **Date Of Birth:**
* **Gender:**
* **Address:**
* **Phone:**

Immunization information

* Influenza Vaccine	* Dose (mL)	*Site / *Date / *Time	* Consent	* Immunizer Information
☐ FLULAVAL -Tetra		**Site:** ☐ Arm Left Deltoid - IM ☐ Arm Right Deltoid – IM ☐ Intranasal ☐ Other:	**Provided by:** ☐ **Client** ☐ **Mature Minor** ☐ **Other → Name and relationship to client** ☐ **In Person** ☐ **Phone** ☐ **Written**	**Name:** **Designation:**
☐ FLUMIST Quadrivalent				
☐ FLUZONE Quadrivalent				
☐ FLUAD				
☐ FLUZONE **HD** Quadrivalent		**Date:** **Time:**		
* **Lot Number :**				

* COVID-19 Vaccine	* Dose (mL)	*Site / *Date / *Time	* Consent	* Immunizer Information
☐ **Moderna** (SPIKEVAX) XBB		**Site:** ☐ Arm Left Deltoid - IM ☐ Arm Right Deltoid – IM ☐ Intranasal ☐ Other:	**Provided by:** ☐ **Client** ☐ **Mature Minor** ☐ **Other → Name and relationship to client** ☐ **In Person** ☐ **Phone** ☐ **Written**	**Name:** **Designation:**
Pfizer (Comirnaty) XBB				
☐ **6 mnths to < 5 yrs**				
☐ **5 yrs to < 12 yrs**				
☐ **12 yrs of age +**		**Date:** **Time:**		
* **Lot Number :**				