fraserhealth

Influenza, COVID-19 and RSV Immunizations Report Form

- Fill in all * *Required fields* * -

CVPs with Provincial E-Form Access MUST Document Directly into the E-Form System

* **Site / Office details** Include FULL site details (Include Location ***AND*** Unit if Acute Care)	HEALTH UNIT STAMP

Client - **Information**	**Immunization information**				
Or place client demographic sticker here	* **Influenza Vaccine**	* **Dose** (mL)	*Site / *Date / *Time	* **Consent**	* **Immunizer Information**
* **Name:**	☐ FluMIST ☐ FluVIRAL		*Site: ☐ Arm Left Deltoid - IM ☐ Arm Right Deltoid – IM ☐ Intranasal ☐ Other: *Date: *Time:	*Provided by: ☐ Client ☐ Mature Minor ☐ Other → Name and relationship to client: ☐ In Person ☐ Phone ☐ Written	*Name: *Designation:
* **PHN:**	☐ FluZONE				
* **Date Of Birth:**	☐ FLUAD (65 yrs +)				
* **Gender:**	* **Lot Number :**				
Address:	* **COVID-19 Vaccine**	* **Dose (mL)**	*Site / *Date / *Time	* **Consent**	* **Immunizer Information**
	☐ Moderna - Pediatric (0.25mL) ☐ Pfizer - 5yrs to 11yrs		*Site: ☐ Arm Left Deltoid - IM ☐ Arm Right Deltoid – IM ☐ Other: *Date: *Time:	*Provided by: ☐ Client ☐ Mature Minor ☐ Other → Name and relationship to client: ☐ In Person ☐ Phone ☐ Written	*Name: *Designation:
* **Phone**:	☐ Moderna - 12yrs+ (0.5mL)				
	☐ Pfizer - 12yrs+				
	* **Lot Number :**				
	* **RSV Vaccine**	* **Dose** (mL)	*Site / *Date / *Time	* **Consent**	* **Immunizer Information**
	☐ mResvia 75 years and older 60 years and older for Indigenous individuals One time vaccination. Booster doses not recommended.		*Site: ☐ Arm Left Deltoid - IM ☐ Arm Right Deltoid – IM ☐ Other: *Date: *Time:	*Provided by: ☐ Client ☐ Mature Minor ☐ Other → Name and relationship to client: ☐ In Person ☐ Phone ☐ Written	*Name: *Designation:
☐ ***Check box if Health Care Worker***	* **Lot Number :**				