fraserhealth

Influenza and COVID-19 Immunizations Report Form - Fill in all * *Required fields*

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

* **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: ***Date:** ***Time:**	***Provided by:** ☐ **Client** ☐ **Mature Minor** ☐ **Other → Name and relationship to client** ☐ **In Person** ☐ **Phone** ☐ **Written**	***Name:** ***Designation:**
☐ FLUMIST - Quadrivalent				
☐ FLUZONE - Quadrivalent				
☐ FLUAD (65 yrs +)				
☐ AFLURIA				
* **Lot Number :**				

* **COVID-19 Vaccine**	* **Dose (mL)**	*Site / *Date / *Time	* **Consent**	* **Immunizer Information**
6 months to 11 years ☐ **Moderna** (SPIKEVAX) KP.2	**0.25 mL**	***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:**
12 years + ☐ **Moderna** (SPIKEVAX) KP.2	**0.5 mL**			
12 years + ☐ **Pfizer (Comirnaty) KP.2**				
* **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: ***Date:** ***Time:**	***Provided by:** ☐ **Client** ☐ **Mature Minor** ☐ **Other → Name and relationship to client** ☐ **In Person** ☐ **Phone** ☐ **Written**	***Name:** ***Designation:**
☐ FLUMIST - Quadrivalent				
☐ FLUZONE - Quadrivalent				
☐ FLUAD (65 yrs +)				
☐ AFLURIA				
* **Lot Number :**				

* **COVID-19 Vaccine**	* **Dose (mL)**	*Site / *Date / *Time	* **Consent**	* **Immunizer Information**
6 months to 11 years ☐ **Moderna** (SPIKEVAX) KP.2	**0.25 mL**	***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:**
12 years + ☐ **Moderna** (SPIKEVAX) KP.2	**0.5 mL**			
12 years + ☐ **Pfizer (Comirnaty) KP.2**				
* **Lot Number :**				