



6 months & older: Injectable Influenza Vaccine Registration Form

All forms can be sent to Deanna Brown at NITHA Confidential Fax: 306-953-5020

Date:		Facility Name:		Vaccine Name:					
Clinic Location:		Phone:		Lot Number:					
Immunizer Name (Printed):				Dose/route all ages: 0.5 ml IM					
Immunizer Name (Signature):									
	HSN	LAST NAME	FIRST NAME	DOB	GENDER	SITE		VACCINE GIVEN: IMMUNIZER INITIALS	<input checked="" type="checkbox"/> Entered in Panorama
				YYYY/MM/DD	F or M	LL LA	RL RA		
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									

USE BOTH SIDES OF FORM

SCAN BOTH SIDES OF THE FORM

6 months & older: Injectable Quadrivalent Influenza Vaccine (QIV) Registration Form

	HSN	LAST NAME	FIRST NAME	DOB	GENDER	SITE		VACCINE GIVEN: IMMUNIZER INITIALS	<input checked="" type="checkbox"/> Entered in Panorama
				YYYY/MM/DD	F or M	LL LA	RL RA		
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									