Adult Influenza/Pneumovax®23 Immunization Record 2018/19

Date: _____

Location: _____

Please complete this section			
Last Name	First Name	First Nation ☐	Date of Birth
Address		On Reserve ☐	PHN/Care Card #
City	Postal Code		Phone

Nurse to complete section below

Agent	Lot #	Consent ☐ Entered ☐
Dose	Route IM ☐ SC ☐	
Site LA ☐ RA ☐	Provider (Print) and Designation (RN, LPN)	

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Agents: FLUVIRAL® INFLUVAC®

Route: **IM** = Intramuscular **SC** = Subcutaneous (PNEUMOVAX ® 23 only)

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