## Child/Youth Influenza Immunization Record 2018/19

Date:							
Location:							
Client to complete this section							
Last Name	First Name			_	First Nation	Date of Birth	
Address					On Reserve	PHN/Care Card #	#
City	Post	Postal Code				Phone	
		Nurse t	to con	nplet	te section belo	ow	
Agent		Lot #				Consent	Entered
Dose		Route	IM		Intranasal	REQUIRES SEC	COND DOSE
Site LL RL LA RA	Provider (Print) and designation (RN, LPN)						
Child/\ Date: Location:					nunization R	Record 2018/19	·
		Client	to co	mple	ete this sectio	n	
Last Name	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		Intranasal	REQUIRES SEC	COND DOSE
Site LL RL LA RA		Provider	(Print)	and o	designation (RN	, LPN)	

Agents: Age 6-23 Months – Fluzone ® Quadrivalent, FLUVIRAL® Age 2-17 yr - Flumist ® Quadrivalent, Fluzone ® Quadrivalent, Fluviral ®, Influvac ® (3-17yrs).

Route: IM = Intramuscular Intranasal for Flumist only