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	Postal Code		Phone
Nurse to complete section below			

Agent	Lot #	Consent ☐ Entered ☐
Dose	Route IM ☐ Intranasal ☐	REQUIRES SECOND DOSE ☐
Site LL ☐ RL ☐ LA ☐ RA ☐	Provider (Print) and 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

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