☐ 2nd dose required→ Date to return to clinic for dose #2:_____

2020-2021 Annual Influenza Immunization Record

Date (YYYY/MM/DD):		Location:
Client Please Complete This Section		
Full Name:		Do you identify as an Indigenous Person of Canada? (check all that apply) □ Yes □ Prefer not to say □ First Nations □ Inuit □Métis □ Status □ Non-Status
Address:		Do you reside in a First Nations Community? ☐ Yes ☐ No
Date of Birth (YYYY/MM/DD): Age:		Health Card Number:
City:	Postal Code:	Phone #:

Please indicate if you have (or have ever had) any of the below conditions:
We ask for this information to help your Nurse to determine if you are eligible for other vaccines or medical services.

□ Arthritis	□ Acid Reflux
□ Asthma	□ Hepatitis B or C
□ Cancer	□ HIV
□ Heart Disease	□ High blood pressure (hypertension)
□ COPD (Chronic obstructive pulmonary disease)	□ Osteoporosis
□ Congestive Heart Failure (CHF)	□ Currently pregnant
□ Dementia	□ Stroke /TIA (transient ischemic attack)
□ Diabetes	□ Blood clots
□ Depression	□ Heart attack
	□ Other chronic condition:

Nurse To Complete Below Section		
Immunizing Agent: □ Fluzone Quadrivalent □ Flumist Quadrivalent □ Agriflu □ Fluviral □ Fluad □ Fluzone High-Dose	Lot #:	☐ Consent Obtained Consent Obtained From:_____ Relationship:_____
Dose: ☐ 0.5mL ☐ 2nd dose required?	Route: □ IM □ IN	Health Centre Name:
Site: □ Left Arm □ Left Leg □ Right Arm □ Right Leg	Provider (print) and Designation (RN, LPN, NP):	