

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

2020-2021 Annual Influenza Immunization Record

Date (YYYY/MM/DD):		Location:	
<i>Client Please Complete This Section</i>			
Full Name:		Do you identify as an Indigenous Person of Canada? (check all that apply) <input type="checkbox"/> Yes <input type="checkbox"/> Prefer not to say <input type="checkbox"/> First Nations <input type="checkbox"/> Inuit <input type="checkbox"/> Métis <input type="checkbox"/> Status <input type="checkbox"/> Non-Status	
Address:		Do you reside in a First Nations Community? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Birth (YYYY/MM/DD):		Health Card Number:	
Age:			
City:	Postal Code:	Phone #:	
<i>Nurse To Complete Below Section</i>			
Immunizing Agent: <input type="checkbox"/> Fluzone Quadrivalent <input type="checkbox"/> Flumist Quadrivalent <input type="checkbox"/> Agriflu <input type="checkbox"/> Fluviral <input type="checkbox"/> Flud <input type="checkbox"/> Fluzone High-Dose		Lot #:	<input type="checkbox"/> Consent Obtained Consent Obtained From: _____ Relationship: _____
Dose: <input type="checkbox"/> 0.5mL <input type="checkbox"/> 2 nd dose required?		Route: <input type="checkbox"/> IM <input type="checkbox"/> IN	Health Centre Name (SDL):
Site: <input type="checkbox"/> Left Arm <input type="checkbox"/> Left Leg <input type="checkbox"/> Right Arm <input type="checkbox"/> Right Leg		Provider (print) and Designation (RN, LPN, NP):	