

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

2021-2022 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 #:	
<p>Please indicate if you have (or have ever had) any of the below conditions: <i>We ask for this information to help your Nurse to determine if you are eligible for other vaccines or medical services.</i></p>			
<input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Heart Disease <input type="checkbox"/> COPD (Chronic obstructive pulmonary disease) <input type="checkbox"/> Congestive Heart Failure (CHF) <input type="checkbox"/> Dementia <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression		<input type="checkbox"/> Acid Reflux <input type="checkbox"/> Hepatitis B or C <input type="checkbox"/> HIV <input type="checkbox"/> High blood pressure (hypertension) <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Currently pregnant <input type="checkbox"/> Stroke /TIA (transient ischemic attack) <input type="checkbox"/> Blood clots <input type="checkbox"/> Heart attack <input type="checkbox"/> Other chronic condition:	
<i>Nurse To Complete Below Section</i>			
Immunizing Agent: <input type="checkbox"/> Flumist Quadrivalent <input type="checkbox"/> Flulaval Tetra <input type="checkbox"/> Afluria Tetra <input type="checkbox"/> Fluzone Quadrivalent <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:
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):	