

IMMUNIZATION REPORT FOR CHILDREN 0-18 YEARS OF AGE

Fax: (807) 625-4828



Name: _____ Date of Birth _____ / _____ / _____

Health Card: _____ Gender _____

Date vaccine administered _____ HCP/Clinic _____

Vaccine	Trade Name	Lot Number
Rot-5	<input type="checkbox"/> Rotateq®	
DTaP-IPV-Hib	<input type="checkbox"/> Pediacel®	
Pneu-C-13	<input type="checkbox"/> Prevnar® 13	
MMR	<input type="checkbox"/> M-M-R® II <input type="checkbox"/> Priorix®	
Men-C-C	<input type="checkbox"/> Menjugate® <input type="checkbox"/> NeisVac-C®	
Varicella	<input type="checkbox"/> Varilrix® <input type="checkbox"/> Varivax® III	
MMRV	<input type="checkbox"/> Priorix-Tetra™ <input type="checkbox"/> ProQuad™	
Tdap-IPV	<input type="checkbox"/> Adacel®-Polio <input type="checkbox"/> Boostrix®-Polio	
Men-C-ACYW135	<input type="checkbox"/> Menactra®	
HB	<input type="checkbox"/> Engerix-B® <input type="checkbox"/> Recombivax HB®	
HPV-9	<input type="checkbox"/> Gardasil® 9	
Tdap	<input type="checkbox"/> Adacel® <input type="checkbox"/> Boostrix®	
Polio	<input type="checkbox"/> Imovax® Polio	
Hib	<input type="checkbox"/> Act-Hib® <input type="checkbox"/> Hiberix®	
Other		

2019IMT-911

Personal information on this form is collected under the authority of the Health Protection and Promotion Act, R.S.O. 1990, as amended and in accordance with the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990 and the Personal Health Information Protection Act, 2004. This information will be used to maintain an immunization record. For questions regarding the collection of your personal information, please contact the Thunder Bay District Health Unit, 999 Balmoral Street, Thunder Bay, ON P7B 6E7. Telephone (807) 625-5900