

# COVID-19 Immunization Form

This form is for **Saskatchewan residents only** to provide notification of a COVID-19 vaccination dose not entered in their electronic record.

All **Personal Information** fields are mandatory; however, **only** provide complete information on the vaccine dose(s) required to be added or updated in your record.

If applicable, check the following box:  Missing Lot Number for vaccines administered within Saskatchewan

**IMPORTANT: Proof of Vaccination** documentation (scanned document or photo) must be attached containing the following information, which must be clearly visible:

- \* Your First and Last **Name**
- \* **Date** Vaccine Administered
- \* Vaccine **Brand** Received
- \* **Location** Where Vaccine Received

**NOTE:** For **In-Province vaccinations**, please provide Saskatchewan wallet card.

Submit form with attached copy of **Proof of Vaccination** documentation to the following email address:

[MySaskHealthRecord@eHealthSask.ca](mailto:MySaskHealthRecord@eHealthSask.ca)

Contact information for **eHealth Saskatchewan: Toll Free: 1-844-767-8259** (Canada and USA)

## Personal Information Required to Record Vaccination:

First Name:	<input type="text"/>	Last Name:	<input type="text"/>
Date of Birth:	YYYY: <input type="text"/> <input type="text"/> MM: <input type="text"/> <input type="text"/> DD: <input type="text"/> <input type="text"/>	Saskatchewan Health Services Number:	<input type="text"/>
Gender:	<input type="radio"/> Female <input type="radio"/> Male <input type="radio"/> Other		
Address:	<input type="text"/>	City:	<input type="text"/>
Postal Code:	<input type="text"/>	Phone:	<input type="text"/>
Email Address:	<input type="text"/>		

## Vaccination Information:

Where was the Vaccination Administered?     In-Province     Out of Province

Vaccine Date:	YYYY: <input type="text"/> <input type="text"/> MM: <input type="text"/> <input type="text"/> DD: <input type="text"/> <input type="text"/>	Clinic/Pharmacy*	<input type="text"/>
Vaccine Location:	Country: <input type="text"/>	City: <input type="text"/>	Vaccine Brand: <input type="text"/>
Vaccine Date:	YYYY: <input type="text"/> <input type="text"/> MM: <input type="text"/> <input type="text"/> DD: <input type="text"/> <input type="text"/>	Clinic/Pharmacy*	<input type="text"/>
Vaccine Location:	Country: <input type="text"/>	City: <input type="text"/>	Vaccine Brand: <input type="text"/>
Vaccine Date:	YYYY: <input type="text"/> <input type="text"/> MM: <input type="text"/> <input type="text"/> DD: <input type="text"/> <input type="text"/>	Clinic/Pharmacy*	<input type="text"/>
Vaccine Location:	Country: <input type="text"/>	City: <input type="text"/>	Vaccine Brand: <input type="text"/>

**IMPORTANT:** Continue to Page 2 to complete form.

\*Not applicable for out of province

**Comments:**

*(Please specify your reason for submitting this form, for example missing lot number, missing dose, duplicate entries, out of province COVID-19 vaccine.)*

- I hereby acknowledge the above information, including attached copy of **Proof of Vaccination** documentation, is accurate and subject to being audited for verification of the information provided.
- If 13 years of age or younger is applicable, make my immunizations visible in MySaskHealthRecord.

**Name:** \_\_\_\_\_  
(type or print name here)

**Date:** \_\_\_\_\_

**FOR PHARMACY USE ONLY**

- I hereby acknowledge the client's proof of vaccination has been verified

\_\_\_\_\_

Pharmacist Name

\_\_\_\_\_

Pharmacist Signature