

**Moderna SPIKEVAX® COVID-19 Vaccine Registration Form 6
Months and Older**

******PLEASE PRINT LEGIBLY******

HCP = Health Care Provider

Fax to 306-787-6296 or 306-787-6259 or Scan both sides and email to: Panoramareportimms@health.gov.sk.ca

- Complete every field Print legibly
- Do not use abbreviations unless specified
- Review for completeness before submitting
- Submit only 1 line list per email
- Provide a contact name and phone number in the email in case follow-up is needed.

Date: _____							Moderna Spikevax®				
Clinic Location (Site and City/Town): _____							Lot Number: _____				
HCP Name (Printed): _____ HCP Designation: <input type="checkbox"/> Physician <input type="checkbox"/> RN							Dosage: 12 years+= 0.5 mL 6 months to 11 years= 0.25 mL				
HCP Name (Signature): _____ <input type="checkbox"/> Other _____							Route: IM				
#	HSN	LAST NAME	FIRST NAME	DOB	GENDER	DOSAGE	SITE	COMMUNITY/CITY OF RESIDENCE	Consent Granted	VACCINE GIVEN: HCP INITIALS	Entered on Panorama
				YYYY/MM/DD	FEMALE MALE OTHER	0.25 ml OR 0.5 ml	LA RA LL RL				
1											
2											
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11											

USE BOTH SIDES OF FORM

SCAN BOTH SIDES OF THE FORM

Moderna Spikevax® COVID-19 Vaccine 6 Months and Older

Date: _____ Clinic Location (Site and City/Town): _____ HCP Name (Printed): _____ HCP Designation: <input type="checkbox"/> Physician <input type="checkbox"/> RN HCP Name (Signature): _____ <input type="checkbox"/> Other _____								Vaccine Name: Moderna Spikevax® Lot Number: _____ Dosage: 12+ years= 0.5 mL 6 months to 11 years= 0.25 mL Route: IM			
#	HSN	LAST NAME	FIRST NAME	DOB	GENDER	DOSAGE	SITE	COMMUNITY/CITY OF RESIDENCE	Consent Granted	VACCINE GIVEN: HCP INITIALS	Entered on Panorama
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