

For 65+ years only: Fluzone High Dose Influenza Vaccine Registration Form

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

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

Clinic Location / Facility Name:				Date:					
Phone:				Lot Number:					
Immunizer Name (Printed):				Dose/route: 0.7 ml IM					
Immunizer Name (Signature):									
	HSN	LAST NAME	FIRST NAME	DOB	GENDER	SITE		VACCINE GIVEN: IMMUNIZER INITIALS	<input checked="" type="checkbox"/> Entered in Panorama
				YYYY/MM/DD	F or M	LA LL	RA RL		
1									
2									
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10									
11									

*****USE BOTH SIDES OF FORM*****

*****SCAN BOTH SIDES OF THE FORM*****

For 65+ years only: Fluzone High Dose Quadrivalent Influenza Vaccine (QIV) Registration Form

	HSN	LAST NAME	FIRST NAME	DOB	GENDER	SITE		VACCINE GIVEN: IMMUNIZER INITIALS	<input checked="" type="checkbox"/> Entered in Panorama
				YYYY/MM/DD	F or M	LL LA	RL RA		
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