



**Fluzone High Dose Quadrivalent Influenza Vaccine (QIV) Registration Form**

HCP = Health Care Provider

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

Scan both sides and email to: [Panoramareportimms@health.gov.sk.ca](mailto:Panoramareportimms@health.gov.sk.ca) or fax to 306-787-6296 or 306-787-6259

Date:				Vaccine Name:					
Clinic Location:			Phone:		Lot Number:				
HCP Name (Printed):				Dose: 0.7 ml					
HCP Name (Signature):				Route: IM					
	HSN	LAST NAME	FIRST NAME	DOB	GENDER	SITE		VACCINE GIVEN: HCP INITIALS	Entered on Panorama
				YYYY/MM/DD	F or M	LL LA	RL RA		
1									
2									
3									
4									
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10									
11									

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

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

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