IMMUNIZATION

Immunization Administration

Reset Form

Provincial Public Health Information Systems PPHIS

Personal Details

Last Name: _____ **First Name:** _____ **DOB:** (yyyy/mm/dd) _____

Health Card No.: _____ **Client ID:** _____ **Gender:** _____

Address: _____ **Tel:** _____

Add Immunization

***Provider:** _____ ***Organization:** _____

***SDL:** _____

***Immunizing Agent:** _____ ***Date Administered:** (yyyy/mm/dd) _____

***Lot Number:** _____ **Dose Number:** **Dosage:** _____

Reason for Immunization[1]: _____

***Site:**

- ☐ Arm - Left
- ☐ Arm - Left deltoid
- ☐ Arm - Left forearm
- ☐ Arm - Right
- ☐ Arm - Right deltoid
- ☐ Arm - Right forearm
- ☐ Buttock
- ☐ Buttock - Left
- ☐ Buttock - Left dorsogluteal
- ☐ Buttock - Left ventrogluteal
- ☐ Buttock - Right
- ☐ Buttock - Right dorsogluteal
- ☐ Buttock - Right ventrogluteal
- ☐ Leg - Left
- ☐ Leg - Left vastus lateralis
- ☐ Leg - Right
- ☐ Leg - Right vastus lateralis
- ☐ Mouth
- ☐ Nares
- ☐ Nares - Left
- ☐ Nares - Right
- ☐ Suprascapular region - Left
- ☐ Suprascapular region - Right
- ☐ Unknown
- ☐ Wound

***Route:** ☐ Infiltrate ☐ Intradermal ☐ Intramuscular ☐ Intranasal ☐ Intravenous ☐ Subcutaneous ☐ Oral ☐ Unknown

Revised Dose #: _____

Revised Dose Reason:

- ☐ Client/Parent/Guardian Reported
- ☐ Divided Dose in Multiple Sites
- ☐ Healthcare provider reported
- ☐ Immunization Dates/Details Not Available
- ☐ MHO Recommendation
- ☐ Other

Revised Dose Comments: _____

Comment: _____

***Immunizing Agent:** _____ ***Date Administered:** (yyyy/mm/dd) _____

***Lot Number:** _____ **Dose Number:** _____ **Dosage:** _____

Reason for Immunization[1]: _____

***Site:**

- ☐ Arm - Left
- ☐ Arm - Left deltoid
- ☐ Arm - Left forearm
- ☐ Arm - Right
- ☐ Arm - Right deltoid
- ☐ Arm - Right forearm
- ☐ Buttock
- ☐ Buttock - Left
- ☐ Buttock - Left dorsogluteal
- ☐ Buttock - Left ventrogluteal
- ☐ Buttock - Right
- ☐ Buttock - Right dorsogluteal
- ☐ Buttock - Right ventrogluteal
- ☐ Leg - Left
- ☐ Leg - Left vastus lateralis
- ☐ Leg - Right
- ☐ Leg - Right vastus lateralis
- ☐ Mouth
- ☐ Nares
- ☐ Nares - Left
- ☐ Nares - Right
- ☐ Suprascapular region - Left
- ☐ Suprascapular region - Right
- ☐ Unknown
- ☐ Wound

***Route:** ☐ Infiltrate ☐ Intradermal ☐ Intramuscular ☐ Intranasal ☐ Intravenous ☐ Subcutaneous ☐ Oral ☐ Unknown

Revised Dose #: _____

Revised Dose Reason:

- ☐ Client/Parent/Guardian Reported
- ☐ Divided Dose in Multiple Sites
- ☐ Healthcare provider reported
- ☐ Immunization Dates/Details Not Available
- ☐ MHO Recommendation
- ☐ Other

Revised Dose Comments: _____

Comment: _____

Notes:

1. **Reasons:** *Contact (Household or Other); High Risk; Occupational hazard; Outbreak; Private Payment; Routine Vaccine; Student Health Care Professional; Travel*