Report of Immunization of Children Age 0-18 years

Physician:___________________________________ **Phone Number:** _____________________________

Please return the completed form to Public Health when all spaces are filled or within one month of the first entry, whichever comes first.

Public Health Fax # 519-836-7215

Student's Information (0-18 Yr.)	Date of Immunization YY/MM/DD	Trade Name of Vaccine (CHECK ✓ ONE per line)																		Lot #
		Adacel	Adacel-IPV	Boostrix	Boostrix-IPV	Engerix	Gardasil	Menactra	Menjugate	MMR II	Pediacel	Prevnar 13	Priorix	Priorix-Tetra	Recombivax	Rotarix	Varilrix	Varivax III	Other *Specify trade name if not in list*	
Surname:																				
First:																				
Sex: M / F OHCN: DOB:																				
Surname:																				
First:																				
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The information on this form is collected under the authority of the Health Promotion and Protection Act in accordance with the Municipal Freedom of Information Protection and Privacy Act and the Provincial Health Information Protection Act. This information will be used for the delivery of public health programs and services, the administration of the organization, the maintenance of health care databases, registries and related research and compliance with legal and regulatory requirements. Any questions about the collection of this information should be addressed to the Chief Privacy Officer at 1-800-265-7293 ext 2975.

1.800.265.7293 www.wdgpublichealth.ca info@wdgpublichealth.ca

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