Vaccine Administration Reporting Form for Health Care Providers

Manitoba

Clinic/Facility/Agency *(service delivery location)*

City/Town/Community

Organization Type *(if known - i.e., Occ. Health, Long-Term Care)*

Person Submitting Form

Contact Phone Number

Date Submitted

PCHs, Hospitals and Occupational Health
Document Reason for Immunization Code
1) Personal Care Home resident
2) High risk environment (e.g., hospital)
3) Routine (e.g., visitor)
4) Occupational hazard (e.g, health care worker, volunteer)

Ensure all information available is entered into each column legibly (All fields are mandatory for data entry except for: "Reason for Immunization")

Client PHIN (9 digit health #)	Last Name	First Name	Date of Birth (YYYY-MM-DD)	Gender (M-F-X)	Vaccine Name	Date Given (YYYY-MM-DD)	Lot Number	Reason for Immunization	Provider Name

Please submit completed form(s) as soon as possible.

Immunizations administered in First Nations Communities
FNIHB Public Health Unit, Fax: 204-983-0519

For all other locations send to your local Public Health Office
(manitoba.ca/health/publichealth/offices.html)

For optimal results print on legal size paper
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