Reciprocal Notification Form

NOVA SCOTIA

Public Health Services DHA ___

novascotia.ca/dhw

This form is to be completed by the person administering a vaccine.
A copy is to be sent to the **local Public Health Office.**
A opy is to be sent to or retained by the health care provider.

PATIENT INFORMATION

Surname | Given Names | Phone Number

Address

Address | Postal Code

If Attending School, Name of School

Y Y Y Y M M D D — Date of Birth | M F Other — Sex | Health Card Number

Health Care Provider's Name *(Please Print)* | Health Care Provider's Phone Number

ANTIGEN ADMINISTERED. CHECK (✓) BOXES WHERE APPROPRIATE

DTaP-IPV-Hib ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ **Meningococcal group C** ☐ **Tdap-IPV**	**Hepatitis B** ☐ 1st ☐ 2nd ☐ 3rd **Hepatitis A** ☐ 1st ☐ 2nd **MMR** ☐ 1st ☐ 2nd	**Varicella** ☐ 1st ☐ 2nd ☐ **Pneumococcal Polysaccharide** ☐ **Td** **MMRV** ☐ 1st ☐ 2nd	**Influenza** ☐ 1st ☐ 2nd ☐ **Hib** ☐ **Tdap** **Other**_____ ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th	**Pneumococcal Conjugate** ☐ 1st ☐ 2nd ☐ 3rd **Hepatitis A & B** ☐ 1st ☐ 2nd ☐ 3rd **Other**_____ ☐ 1st ☐ 2nd ☐ 3rd
Site:	Site:	Site:	Site:	Site:
Dosage:	Dosage:	Dosage:	Dosage:	Dosage:
Route:	Route:	Route:	Route:	Route:
Lot #:	Lot #:	Lot #:	Lot #:	Lot #:

Date Given (YY/MM/DD) | Signature of Person Giving Vaccine

Office / Location where Immunization was Given