Public Health Services
CAPITAL HEALTH

Childhood Immunization Record

Important Instructions (refer to the NS Childhood Immunization Schedule)

Complete this form and keep as the patient record. Provide a copy to parent/guardian for entry to child care centre, summer camp, college/university. Provide a copy to Public Health Services in one of the following ways:

Fax: (902)481-8928

Mail: Immunization Program - PHS, 7 Mellor Ave, Unit 5, Dartmouth, NS B3B 0E8

Patient Information/Client Profile

Last Name	First Name	❑ Male ❑ Female ❑ Transgendered
Health Card Number	Date of Birth (Year / Month / Day)	Child Care Centre/School/Grade
Family Physician and Telephone Number		Postal Code

IMMUNIZATIONS GIVEN

Document immunization history of child, please note if source is not current provider.

Age Due	Date Given (YYYY/MM/DD)	Vaccine	Trade Name	Lot Number	Site	Route	Dose	Given By (Initial)
2 months		DTaP-IPV-Hib						
2 months		Pneumococcal Conjugate						
4 months		DTaP-IPV-Hib						
4 months		Pneumococcal Conjugate						
6 months		DTaP-IPV-Hib						
6 months		Pneumococcal Conjugate						
12 months		MMR						
12 months		Men C Conjugate						
12 months		Varicella*						
18 months		DTaP-IPV-Hib						
18 months		Pneumococcal Conjugate						
4-6 years		DTaP-IPV						
4-6 years		MMR						
Flu (>6 mos)		Influenza						
Other								
Other								
Other								
Other								
Other								
Grade 7		HPV						
Grade 7		Tdap						
Grade 7		Hepatitis B						
Grade 7		Men C Conjugate						

Suggestion for Reporting to Public Health:

- ❑ **Send copy of record following 12 month visit**
- ❑ **Send copy of record following 18 month visit**
- ❑ **Send copy of record following 4-6 yrs (pre-school) visit**

Signature of Provider:	Office Information:

Public Health Services
CAPITAL HEALTH

Adult Immunization Record

Important Instructions (refer to the NS Adult Immunization Schedule)

Complete this form and keep as the patient record. Provide a copy to patient for employment, travel or college/university. Provide a copy to Public Health Services in one of the following ways:

Fax: (902)481-8928

Mail: Immunization Program - PHS, 7 Mellor Ave, Unit 5, Dartmouth, NS B3B 0E8

Patient Information/Client Profile

Last Name	First Name	❑ Male ❑ Female ❑ Transgendered
Health Card Number	Date of Birth (Year / Month / Day)	College/University
Family Physician and Telephone Number		Postal Code

IMMUNIZATIONS GIVEN

Document immunization history, please note if source is not current provider. Some vaccines recommended for adults are not publicly funded, ie. vaccines for travel, school, employment. Please refer to high-risk populations and publicly funded vaccines, or contact public health with questions about eligibility.

Due	Date Given (YYYY/MM/DD)	Vaccine	Trade Name	Lot Number	Site	Route	Dose	Given By (Initial)
>22 yrs		Tdap (one dose)						
Annually		Flu (eligible groups)						
> 65 yrs		Pneumo Polyscaccharide						
q 10 yrs		Adult Booster						
Travel		IPV (one dose)						
Other								
Other								
Other								
Other								
Other								
Other								
Other								
Other								
Other								
Other								
Other								
Other								
Other								
Other								
Other								

Suggestion for Reporting to Public Health:

- ❑ **Send copy of record following annual flu shot**
- ❑ **Send copy of record following 65 yr health visit**
- ❑ **Send copy of record following travel/school/employment, when series completed**

Signature of Provider:	Office Information: