

Vaccine Administration Reporting Form for Health Care Providers



Name of Location (Service Delivery Location)

Person Submitting Form

City/Town/Community

Contact Phone Number

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

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 #)	First Name	Last Name	Date of Birth (YYYY-MM-DD)	Gender (M/F/X)	Vaccine Name	Date Given (YYYY-MM-DD)	Lot Number	Dosage, Site and Route	Reason for Immunization	Provider Name