



WA Paediatric Flu Immunisation Program VACCINE RE-ORDER FORM

Fax To: 9388 4820

Practice Name: _____

Date: / /

Telephone: _____

Practice Number*: _____

Facsimile: _____

*(CSL Practice Number is required for processing of vaccines) Region: **WHEATBELT**

Number of Pages in this fax: _____

	FIRST NAME (Please print legibly)	SURNAME (Please print legibly)	Child' Date of Birth	2009		Has this child ever had ≥2 doses of flu vaccine prior to 2009?
				Date Flu Vaccine Given	Is this the child's 1st or 2nd dose for this year? c 1st c 2nd	
1			___/___/___	___/___/09	c 1st c 2nd	c Yes c No c Unsure
2			___/___/___	___/___/09	c 1st c 2nd	c Yes c No c Unsure
3			___/___/___	___/___/09	c 1st c 2nd	c Yes c No c Unsure
4			___/___/___	___/___/09	c 1st c 2nd	c Yes c No c Unsure
5			___/___/___	___/___/09	c 1st c 2nd	c Yes c No c Unsure
6			___/___/___	___/___/09	c 1st c 2nd	c Yes c No c Unsure
7			___/___/___	___/___/09	c 1st c 2nd	c Yes c No c Unsure
8			___/___/___	___/___/09	c 1st c 2nd	c Yes c No c Unsure
9			___/___/___	___/___/09	c 1st c 2nd	c Yes c No c Unsure
10			___/___/___	___/___/09	c 1st c 2nd	c Yes c No c Unsure
11			___/___/___	___/___/09	c 1st c 2nd	c Yes c No c Unsure
12			___/___/___	___/___/09	c 1st c 2nd	c Yes c No c Unsure
13			___/___/___	___/___/09	c 1st c 2nd	c Yes c No c Unsure
14			___/___/___	___/___/09	c 1st c 2nd	c Yes c No c Unsure
15			___/___/___	___/___/09	c 1st c 2nd	c Yes c No c Unsure
16			___/___/___	___/___/09	c 1st c 2nd	c Yes c No c Unsure
17			___/___/___	___/___/09	c 1st c 2nd	c Yes c No c Unsure
18			___/___/___	___/___/09	c 1st c 2nd	c Yes c No c Unsure
19			___/___/___	___/___/09	c 1st c 2nd	c Yes c No c Unsure
20			___/___/___	___/___/09	c 1st c 2nd	c Yes c No c Unsure

