PRESCRIPTION
PRIMARY HEALTHCARE PROVIDER NOTIFICATION

Name of Primary Healthcare Provider:	Fax:

After assessment of immunization status, health status and travel risks, prescription(s) for the following vaccines and / or medications were issued for:

Name:	Provincial Health Services Number:
Address:	Date of Birth:
	¨ Male ¨ Female ¨ Other
Telephone:	Email:
Parent/Guardian (if applicable):	Pregnant/Breastfeeding:

Vaccine/Medication	Rationale	Dosage (Only check one)	Route (Only check one)
		□ 0.5mL □ 1.0 mL □ Other:	□ IM □ PO □ Other: □ ID □ SC
		□ 0.5 mL □ 1.0 mL □ Other:	□ IM □ PO □ Other: □ SC □ ID
		□ 0.5 mL □ 1.0 mL □ Other:	□ IM □ PO □ Other: □ SC □ ID
		□ 0.5mL □ 1.0 mL □ Other:	□ IM □ PO □ Other: □ SC □ ID

Prescribing Pharmacist:

Name:	Signature:	
Pharmacy:	Telephone:	Fax:
Email:	Date:	