# Immunization Reporting of Children Age 0-18 years

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
*Stay Well.*

**Physician Name:** _____ **Phone Number:** _____

***Please fill in the required information or place a patient label in the space provided.**

| Child Name *(Last, First)* | Sex *(M / F)* | Health Card # | Birthdate *(yyyy/mm/dd)* | Immunization Date *(yyyy/mm/dd)* | Vaccine *(Trade name)* | Lot # |
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**Fax completed form to:**
**519.836.2986**

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