Interior Health

ADULT VACCINE RETURN FORM

Name of Physician/Nurse Practitioner/CVP :_____

Address: _____

Telephone number: _____ Fax: _____

PRODUCT DESCRIPTION	LOT NUMBER	EXPIRY DATE YY/MM/DD	REASON FOR RETURN	DOSES
Cervarix (HPV)				
Hepatitis A				
Hepatitis B				
Measles/Mumps/Rubella (MMR)				
Pneumococcal Polysaccharide 23				
Polio (IPV)				
Tetanus/Diphtheria (Td)				
Varicella				
Other				

Submit this form with vaccines to your local health centre

Reasons for Return:	**Name of person returning vaccine:**
☐ Expired product ☐ Surplus/over-ordered, good shelf-life ☐ Cold chain failure – fridge failure/power outage ☐ Recall ☐ Other – specify: _____	_____ Date: _____

Health Unit Stamp