Interior Health

CHILDHOOD VACCINE RETURN FORM

Name of Physician:_____

Address: _____

Telephone number: _____ Fax: _____

PRODUCT DESCRIPTION	LOT NUMBER	EXPIRY DATE YY/MM/DD	REASON FOR RETURN	DOSES
Diphtheria/Tetanus/acellular Pertussis/HB/IPV/Hib (INFANRIX hexa™)				
Diphtheria/Tetanus/acellular Pertussis/IPV/Hib (PEDIACEL® OR INFANRIX®-IPV/Hib)				
Diphtheria/Tetanus/acellular Pertussis/IPV (QUADRACEL® or INFANRIX®-IPV)				
Hepatitis A (Aboriginal infants only)				
Hepatitis B (infant)				
Measles/Mumps/Rubella (MMR)				
Meningococcal C Conjugate				
Pneumococcal Conjugate				
Rotavirus				
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