INTERIM FEDERAL HEALTH PROGRAM

Vaccination Documentation Worksheet
To Be Completed by Health Care Providers of the Interim Federal Health Program (IFHP) Overseas
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Name (Last, First)	Birth date (mm-dd-yyyy)	IME Exam date (mm-dd-yyyy)	If vaccines not administered - indicate reason(s) below. Mark all that apply: A,B,C,D,E,F,G
IRCC Immigration application number:	UCI number:		

Immunization record: *Include vaccine history transferred from a reliable source/record. List chronologically from left to right. Provide date as mm-dd-yyyy*					*Include vaccine(s) provided by the provider*			Test for immunity	
Vaccine	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**	
Diphtheria, Tetanus, Pertussis									
□ DTP, DTaP									
□ DT									
□ Td									
□ Tdap									
Polio									
□ OPV									
□ IPV									
Measles Mumps Rubella									
□ MMR									
□ Measles									
□ Mumps									
□ Rubella									
Rotavirus									
□ RotaTeq (RV5)									
□ Rotarix (RV1)									
□ other rotavirus vaccine									
Hib									
Hepatitis A									
Hepatitis B									
Meningococcal vaccine									
□ MCV4 (conjugate)									
□ Other meningococcal vaccine									
Varicella									
□ Vaccine									
□ Varicella history									
Pneumococcal									
□ PCV 7 (conjugate)									
□ PCV 10 (conjugate)									
□ PCV 13 (conjugate)									
□ PPSV 23 (polysaccharide)									
Influenza									
Other									
Other									
Other									

Health-care provider name (printed)	Provider signature/stamp	Date (mm-dd-yyyy)
_____	_____	_____
I attest that I documented all reliable vaccination history and all vaccines administered by the panel site		

Immigration, Refugees and Citizenship Canada
Immigration, Réfugiés et Citoyenneté Canada

Reason(s) for not providing vaccines: A - Not age appropriate; B - Insufficient time interval to complete series; C – contraindication; D - Not routinely available; E- Not flu season; F - Known hepatitis B infection, G - Applicant refused vaccinations

Contraindications:

□ Pregnant
□ Immune compromised
□ History of allergic reaction to vaccine or vaccine component
□ Other reaction to vaccine
□ Current illness
□ Other, specify:

Remarks (*document any vaccine-specific details including contraindications to vaccination or adverse events*):