SOUTHWESTERN Public Health
Oxford • Elgin • St.Thomas

PUBLICLY FUNDED HIGH RISK & SCHOOL PROGRAM

Vaccine order form

FAX TO: 519-539-6206
www.swpublichealth.ca

> Refer to the Publicly Funded Immunization Schedules for Ontario for more details <

☐ *I have attached a copy of our fridge temperatures since our last order to verify that vaccine has been stored between +2°C and +8°C and min/max temperatures have been recorded twice daily.*

Orders received by Monday at 3:30 p.m. will be available for pick up at 410 Buller St., Woodstock on Thursday of the same week

Name of facility, physician, or practice:	
Temp log verified, attached, and order completed by:	
Date:	**Contact number:**

Hepatitis A (Avaxim/Havrix/Vaqta)		**ELIGIBILITY ≥ 1 year and:** (check all that apply)
NAME (First & Last):	DOB (YYYY/MM/DD):	☐ Chronic liver disease ☐ Anyone engaging in IV drug use ☐ Men who have sex with men
DOSE # (please circle dose required): **1 2**		

Haemophilus influenzae type B (Act-HIB)		**ELIGIBILITY ≥ 5 years and:** (check all that apply)
NAME (First & Last):	DOB (YYYY/MM/DD):	☐ Hematopoietic stem cell transplant (HSCT) recipient* (3 doses) ☐ Functional or anatomic asplenia (1 dose) ☐ Immunocompromised related to disease or therapy (1 dose) ☐ Bone marrow or solid organ transplant recipient (1 dose) ☐ Lung transplant recipient (1 dose) ☐ Cochlear implant recipient (pre/post implant) (1 dose) ☐ Primary antibody deficiency (1 dose)
DOSE # (please circle dose required): **1 2 3**		

Meningococcal B (Bexsero)		**ELIGIBILITY Age 2m-17 years with:** (check all that apply)
NAME (First & Last):	DOB (YYYY/MM/DD):	☐ Functional or anatomic asplenia ☐ Complement, properdin, factor D deficiency, or primary antibody deficiency ☐ Cochlear implant recipient (pre/post implant) ☐ Acquired complement deficiency ☐ HIV
DOSE # (please circle dose required): **1 2 3 4**		

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Name of facility, physician, or practice:

Meningococcal C-ACYW135 (Menactra/Nimenrix)

NAME (First & Last):

DOB (YYYY/MM/DD):

DOSE # (please circle dose required): **1 2 3 4 BOOSTER**

ELIGIBILITY ≥ Age 9 months and: (check all that apply)

- ☐ Functional or anatomic asplenia
- ☐ Complement, properdin, factor D deficiency, or primary antibody deficiency
- ☐ Cochlear implant recipient
- ☐ HIV
- ☐ Anyone born 1997 or after
- ☐ All students grade 7-12

Hepatitis B (Recombivax HB/Engerix-B)

NAME (First & Last):

DOB (YYYY/MM/DD):

DOSE # (please circle dose required): **1 2 3 4**

☐ High dose (40mcg) needed—for people ≥ 20 years of age with dialysis, chronic renal failure, and some immunocompromised people

Scheduling:

11-15 years: 1mL given at 0 and 4-6m (6m if Engerix is used, 4-6m if Recombivax is used)
This is the schedule used for grade 7 school clinics and must be completed before turning 16

0-19 years: 0.5mL given at 0, 1, and 6m

20+ years: 1mL given at 0, 1, and 6m

ELIGIBILITY ≥ 0 years and: (check all that apply)

- ☐ Infant born to Hep B-positive mother:
  - 4 doses for premature infant weighing <2000g at birth
  - 3 doses for full/post term infants or premature infants weighing ≥ 2000g
- ☐ Household or sexual contact of chronic acute case (3 doses)
- ☐ Anyone engaging in IV drug use(3 doses)
- ☐ Men who have sex with men, individual with multiple sex partners, or history of STI (3 doses)
- ☐ Needle stick injury in a non-health care setting (3 doses)
- ☐ Child <7 years old who has immigrated from country of high prevalence for hepatitis B and who may be exposed to hepatitis B carriers through their extended family (3 doses)
- ☐ Chronic liver disease including hepatitis B and C (3 doses)
- ☐ Renal dialysis or disease requiring frequent receipt of blood products (e.g., haemophilia) (2nd and 3rd doses only)
- ☐ Awaiting liver transplant (2nd and 3rd doses only)
- ☐ All students grade 7-12

HPV-9 (Gardasil 9)

NAME (First & Last):

DOB (YYYY/MM/DD):

DOSE # (please circle dose required): **1 2 3**

Scheduling:

9-20 years of age: 1 dose

21 years of age and older: 2 doses at 24 weeks apart

All ages immunocompromised: 3 doses at 0, 2, and 6 months

ELIGIBILITY 9-26 years and: (check all that apply)

- ☐ Men who have sex with men
- ☐ All students grade 7-12

Please report all vaccines once given. Fax to 519-539-6206.

PATIENT'S NAME	DOB (YYYY/MM/DD)	VACCINE NAME	LOT#	DATE GIVEN (YYYY/MM/DD)