



2026-27 COVID-19/Influenza Vaccine 6 months – 11 Years Dose Administration Tool

CLIENT INFO		
LAST NAME		FIRST NAME
DOB YYYY/MM/DD	AGE	GENDER
HEALTH CARD NUMBER		PHONE NUMBER
ADDRESS		
CITY		POSTAL CODE
VACCINE SELECTION		
Please select the vaccine(s) you are requesting to receive today: ☐ COVID-19 ☐ Influenza		
CONSENT		
☐ I am the parent, legal guardian, or authorized substitute decision-maker for the individual named on this form and wish for them to receive the vaccine(s) selected, subject to discussion and consent confirmation with the immunizing health care provider. Name of Person Providing Consent (Print): _____		



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FOR CLINIC USE ONLY

ASSESSMENT

- ☐ I have assessed the client's age
- ☐ I have assessed the client's eligibility
- ☐ I have completed the screening questions
- ☐ I have obtained verbal consent

CLIENT AGE

INITIALS

COVID-19 (6 months to 11 years)

VACCINE	DOSE	SITE	ROUTE	Lot #/EXPIRY	DATE & TIME	GIVEN BY
SPIKEVAX (Moderna)	0.25 mL	Left or Right Deltoid or Vastus Lateralis	IM			

INFLUENZA (≥ 6 months)

FLUCELVAX (Seqirus)	0.5 mL	Left or Right Deltoid or Vastus Lateralis	IM			
FLUZONE (Sanofi)	0.5 mL	Left or Right Deltoid or Vastus Lateralis	IM			
FLUVIRAL (GSK)	0.5 mL	Left or Right Deltoid or Vastus Lateralis	IM			

COMMENTS

☐ Entered in Panorama