



**APPENDIX F: Record of Rabies Vaccine and Rabies Immune Globulin Administration**

Please complete the following information and fax it to your local health unit at:  
( ) \_\_\_\_\_.

**Health Unit: Please record in iPHIS.** If iPHIS is not utilized, fax to Biologicals Desk at (604) 707-2581.

CLIENT INFORMATION		
Last Name:	First Name:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Personal Health No.	
Date of Birth: ____/____/____ (yyyy/mm/dd)		
No. and Street Address:		
City/Town:	Postal Code:	
RABIES VACCINE		
Dose 1: _____ (yyyy/mm/dd)	Lot #: _____ Site: _____	#1 _____ (Provider)
Dose 2: _____ (yyyy/mm/dd)	Lot #: _____ Site: _____	#2 _____ (Provider)
Dose 3: _____ (yyyy/mm/dd)	Lot #: _____ Site: _____	#3 _____ (Provider)
Dose 4: _____ (yyyy/mm/dd)	Lot #: _____ Site: _____	#4 _____ (Provider)
Dose 5: _____ (yyyy/mm/dd) <small>(dose 5 needed only if immunocompromised)</small>	Lot #: _____ Site: _____	#5 _____ (Provider)
RABIES IMMUNE GLOBULIN		
Date administered: _____ (yyyy/mm/dd)		
Lot #(s): _____		
Provider: _____		