BC Centre for Disease Control

Record of Rabies Vaccine and Rabies Immune Globulin Administration
May 2016

Provider: Please complete and fax to your local health unit at: ( )_____.
Health Unit: Please record in Panorama.

CLIENT INFORMATION		
Last Name:		First Name:
Sex: ☐ Male ☐ Female		PHN:
Date of Birth: _____/_____/_____ (*yyyy/mm/dd)*		
No. and Street Address:		
City/Town:		Postal Code:
RABIES VACCINE		
Dose 1: _____ (yyyy/mm/dd) Dose 2: _____ (yyyy/mm/dd) Dose 3: _____ (yyyy/mm/dd) Dose 4: _____ (yyyy/mm/dd) Dose 5: _____ (yyyy/mm/dd) (dose 5 needed only if immunocompromised or on chloroquine)	Lot #: _____ Site: _____ Lot #: _____ Site: _____ Lot #: _____ Site: _____ Lot #: _____ Site: _____ Lot #: _____ Site: _____	#1 _____ (Provider) #2 _____ (Provider) #3 _____ (Provider) #4 _____ (Provider) #5 _____ (Provider)
RABIES IMMUNE GLOBULIN		
Date administered: _____ (yyyy/mm/dd) Site(s): _____ _____ _____ Lot(s) #: _____ _____ _____ Dosage(s): _____ _____ _____ Provider: _____		