Pharmacist Vaccination Record Form

Physical location (e.g. community pharmacy): _____

Date faxed: _____

Please record Date of Birth (DOB), gender, Aboriginal or Torres Strait Islander status, vaccine given and administering pharmacist details.

Please fax completed forms to ACT Health, Pharmaceutical Services.

Fax Number: 6205 0997

No.	Date of Birth	Gender	Aboriginal or Torres Strait Islander	Date vaccine given	Type of vaccination given	Administering pharmacist
	(dd/mm/yy)	*(m/f)*	*(y/n)*	*(dd/mm/yy)*	*(influenza / dTpa)*	
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