DRUG ADMINISTRATION NOTIFICATION

☐ Response Required ☐ For your records Date: _____

TO:	REGARDING:
Provider	Patient:
Tel:	DOB:
Fax:	HCN:

Date of Administration			Time
Drug Administered	Drug	DIN	Lot
	Site and Route		Dose # in series (if applicable)
Planned Follow-Up	☐ N/A		
Details			
Adverse Events	☐ N/A		
AEFI Completed	☐		
Details			

Pharmacy Practitioner Information:

Authorizing Pharmacist	
Signature	
Administrator/Immunizer	
Signature	
Pharmacy Name	Phone/Fax