



## Non-Reusable Vaccine Wastage Return Record

Attach this completed form when returning vaccines to Public Health.

Name of Practice: _____ Date: _____
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### Vaccine Return Records

Check the product(s) you are returning. Indicate the reason for return:

- |  |  |
|--|--|
| <p>A. Expired<br/>         B. Exposed Temperatures</p> | <p>C. Excessive Quantities Ordered<br/>         D. Other (Specify)</p> |
|--|--|

Vaccine	Lot #	# of Doses	Reason for Return (Select A, B, C or D)
<input type="checkbox"/> Act-Hib®			A   B   C   D
<input type="checkbox"/> Hiberix®			A   B   C   D
<input type="checkbox"/> Adacel®			A   B   C   D
<input type="checkbox"/> Boostrix®			A   B   C   D
<input type="checkbox"/> Adacel-IPV®			A   B   C   D
<input type="checkbox"/> Boostrix-Polio®			A   B   C   D
<input type="checkbox"/> Engerix B®			A   B   C   D
<input type="checkbox"/> Recombivax® Adult			A   B   C   D
<input type="checkbox"/> Gardasil® 1 Dose			A   B   C   D
<input type="checkbox"/> Gardasil® 10 Dose			A   B   C   D
<input type="checkbox"/> Havrix®			A   B   C   D
<input type="checkbox"/> Vaqta®			A   B   C   D



Vaccine Program Inventory

110 King Street West, 2nd Floor, Hamilton, ON L8P 4S6

Phone: 905-546-2424 ext 2161 • Fax: 905-546-3472

[PublicHealth.Medorders@hamilton](mailto:PublicHealth.Medorders@hamilton)

Vaccine	Lot #	# of Doses	Reason for Return (Select A, B, C or D)
<input type="checkbox"/> Imovax Polio®			A B C D
<input type="checkbox"/> Influenza Vaccine Specify Brand: _____			A B C D
<input type="checkbox"/> Menactra® 1 Dose			A B C D
<input type="checkbox"/> Menactra® 5 Dose			A B C D
<input type="checkbox"/> Menjugate®			A B C D
<input type="checkbox"/> Neisvac®			A B C D
<input type="checkbox"/> MMR® II			A B C D
<input type="checkbox"/> Priorix®			A B C D
<input type="checkbox"/> Pediacel®			A B C D
<input type="checkbox"/> Pentacel®			A B C D
<input type="checkbox"/> Pneumovax® 23			A B C D
<input type="checkbox"/> Prevnar®™ 20			A B C D
<input type="checkbox"/> Prevnar™ 13			A B C D
<input type="checkbox"/> Vaxneuvance®			A B C D
<input type="checkbox"/> Priorix-Tetra®			A B C D
<input type="checkbox"/> ProQuad®			A B C D
<input type="checkbox"/> Rotarix <sup>1</sup> ® 10 Dose			A B C D
<input type="checkbox"/> Shingrix® 1 Dose			A B C D



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<input type="checkbox"/> Td <sup>®</sup> Adsorbed			A B C D
<input type="checkbox"/> Tenivac <sup>®</sup>			A B C D
<input type="checkbox"/> Tubersol <sup>®</sup> (Specify if vial open)			A B C D
<input type="checkbox"/> Varilrix <sup>®</sup>			A B C D
<input type="checkbox"/> Varivax <sup>®</sup> III			A B C D
<input type="checkbox"/> HyperRab <sup>®</sup>			A B C D
<input type="checkbox"/> KamRab <sup>®</sup>			A B C D
<input type="checkbox"/> Imovax <sup>®</sup>			A B C D
<input type="checkbox"/> RabAvert <sup>®</sup>			A B C D
<input type="checkbox"/> Other			A B C D