

## Rabies Vaccine/Immune Globulin USAGE REPORT

Date: \_\_\_\_\_ Physician/Health Facility: \_\_\_\_\_  
yyyy/mm/dd

Contact Person: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
yyyy/mm/dd

Address: \_\_\_\_\_

Date Treatment Started: \_\_\_\_\_ Date Treatment Completed: \_\_\_\_\_  
yyyy/mm/dd yyyy/mm/dd

Description	Number Required	Lot Number(s)	Expiry Date	Date Administered	Signature
Rabies Immune Globulin					
Rabies Vaccine (Day 0)					
Rabies Vaccine (Day 3)					
Rabies Vaccine (Day 7)					
Rabies Vaccine (Day 14)					
Rabies Vaccine (Day 28)					

\_\_\_\_\_  
Name (print)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Fax completed form to the North Bay Parry Sound District Health Unit at (705) 474-9481**  
*(please keep a copy for your records)*