



Texas Vaccines for Children (TVFC)

Influenza Vaccine Order Form

PIN _____

OCTOBER* CLINIC DAYS AND HOURS

	AM	PM
MONDAY	_____ to _____	_____ to _____
TUESDAY	_____ to _____	_____ to _____
WEDNESDAY	_____ to _____	_____ to _____
THURSDAY	_____ to _____	_____ to _____
FRIDAY	_____ to _____	_____ to _____

Contact Person
 (____) _____ (____) _____
 Phone Fax

Clinic Name and Address:

Closed:

* Vaccines may not be received in October

Given a choice about flu formulation, which would you choose and how many doses of each?

VACCINE	FORMULATION	AGE GROUP	REQUESTED QUANTITY IN DOSES
No preference/ First available	0.25 mL each	6-35 months	
No preference/ First available	0.5 mL doses	36 mos-18 yrs	

VACCINE	FORMULATION	AGE GROUP	REQUESTED QUANTITY IN DOSES
FluZone® PF (Sanofi Pasteur)	Prefilled Syringes 0.25 mL each	6-35 months	
FluZone® PF (Sanofi Pasteur)	Vials 1 dose each or Prefilled Syringes 0.5 mL each	36 mos-18 yrs	
FluZone® (Sanofi Pasteur)	Multidose Vial 0.5 mL doses	36 mos-18 yrs	
Fluvirin® (Novartis)	Multidose Vial 0.5 mL doses	4-18 years	

If FluMist is not available, it will be replaced with another product.

FluMist® Live Virus (MedImmune)	Prefilled Single Use Sprayers 0.2 mL each	5-18 years	
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Vaccine Information Statements (VIS) will be mailed separate from vaccines. Indicate the number needed below.

English VIS	_____	Spanish VIS	_____
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Date of Order _____

Approved (Authorized signature) _____

COMMENTS:
