

Nurse's name: _____ Clinic location: _____

Note: This form is used for the purpose of inventory reconciliation for influenza vaccine documented in CMOIS/MOIS.

Date (YY-MM-DD)	Influenza Product				Lot #	Entered in Electronic Medical Record (EMR)
	Fluad	FluMist	Fluzone	Fluzone HD*		
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Date (YY-MM-DD)	Influenza Product				Lot #	Entered in Electronic Medical Record (EMR)
	Fluad	FluMist	Fluzone	Fluzone HD*		
Totals						
Wastage						

