Maryland Vaccines For Children Program

2011-2012 Influenza Vaccine Inventory/Order Form

Date:____/_____/_____

PIN (required): _____ **Facility Name:**_____

Delivery Address (if new):_____

Contact Name:_____ **Phone #:**_____ **Email:**_____

Fax #:_____**Special Delivery Instructions:**_____

Fax to: 410 333-5893

Write in the TOTAL number of doses of VFC Influenza vaccine you currently have on hand.

VACCINE	Total # OF VFC doses on hand
LAIV FluMist®	_____
Sanofi MDV (for kids 6 mos & older)	_____
Sanofi .25mL Pre-filled Syringes (for kids 6 months through 35 months)	_____

If you would like to order additional doses of VFC Seasonal Influenza vaccine, please indicate the vaccine formulation and the number of doses for each formulation.

VACCINE	How many doses are you requesting?
LAIV FluMist®	_____
Sanofi MDV (for kids 6 mos & older)	_____

Please expect delivery within 2 weeks of faxing this form

Fax this form to the VFC Program 410 333-5893