

Facility ID: _____ Vaccination #: _____

Healthcare Worker Demographics

*HCW ID#: _____

HCW Name, Last: _____ First: _____ Middle: _____

*Gender: F M Other *Date of Birth: _____

*Work Location: _____ *Occupation: _____ Clinical Specialty: _____

*Performs direct patient care: Yes No

Vaccination Details

*Type of vaccination: **Influenza**

*Influenza subtype: Seasonal (years) _____ Non-seasonal (years) _____

*Do you plan to use this information to satisfy federal record-keeping requirements for the administration of vaccine covered by the Vaccine Injury Compensation Program? Yes No

*Vaccine administered: Onsite at this facility
 Offsite at a location other than this facility
 Declined due to medical contraindications (e.g.,allergy to vaccine components)
 Declined due to personal reasons
 If declined for personal reasons: (check all that apply)
 Fear of needles/injections
 Fear of side effects
 Perceived ineffectiveness of vaccine
 Religious or philosophical objections
 Concern for transmitting vaccine virus to contacts
 Other (specify): _____

*Date of vaccination: ____ / ____ / ____
mm dd yyyy

*Product: (check one) Seasonal: Afluria® Agriflu®
 Non-seasonal: 2009 H1N1: CSL Limited
 Fluarix® Novartis and Diagnostics, Ltd.
 Flulaval® Sanofi Pasteur, Inc.
 Flumist® MedImmune LLC
 Fluvirin® Other (please specify) _____

Fluzone®

*Lot number: _____ Manufacturer: _____

*Type of influenza vaccine: Live attenuated (LAIV) [e.g., nasal (Flumist®)]
 Inactivated vaccine(TIV)[e.g., injectable(Fluvirin®,Fluzone®,Fluarix®, FluLaval®, Afluria®)]

*Route of administration: Intramuscular
 Intranasal
 Subcutaneous

Event Details (cont.)

*Adverse reaction to vaccine: Yes No Don't know

If Yes, check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Arthralgia | <input type="checkbox"/> Pain/soreness at injection site |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Rash, generalized |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Rash, localized |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Rhinorrhea |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Shortness of breath/difficulty breathing |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Malaise/fatigue | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Myalgia | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Nasal congestion | |

Which vaccine information statement, including edition date, was provided to the vaccinee?

- Live Attenuated Influenza Vaccine Information Statement
 Inactivated Influenza Vaccine Information Statement

Edition date: ____ / ____ / ____
mm dd yyyy

Person Administering Vaccine

Vaccinator ID : _____ (This is the HCW ID# for the vaccinator)
 Name, Last: _____ First: _____ Middle: _____
 Title: _____
 Work address: _____
 City: _____ State: _____ Zip code: _____

Custom Fields

Label	Label
_____ / ____ / ____	_____ / ____ / ____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Comments
