



Healthcare Worker Influenza Vaccination

* Facility ID #: _____ * Vaccination ID #: _____

Healthcare Worker Demographics:

* HCW ID #: _____
HCW Name, Last: _____ First: _____ Middle: _____
* Gender: _____ * Date of Birth: ____ / ____ / ____
* Performs direct patient care: ____ Y ____ N

Event Details:

* Type of vaccination: Influenza For season: _____
(specify years)

* Vaccine administered: ___ Onsite at this facility
___ Offsite at a location other than this facility
___ Declined vaccination

Reasons for declining: (select all that apply)

- ___ Fear of needles/injections
- ___ Fear of side effects
- ___ Perceived ineffectiveness of vaccine
- ___ Religious objections
- ___ Medical contraindications (e.g., allergy to vaccine components)
- ___ Current respiratory infection
- ___ Concern for transmitting vaccine virus to contacts
- ___ Other (specify): _____

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

* Product: (check one) ___ Flumist® Manufacturer: _____
___ Fluvirin®
___ Fluzone®
___ Fluarix®

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

* Route of administration: ___ Intramuscular ___ Subcutaneous ___ Intranasal
* Lot number: _____

* = Required for vaccines that are administered ONSITE.

Assurance of Confidentiality: The information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666).

* Adverse reaction to vaccine: ___ Y ___ N ___ Don't know

If YES, select all that apply.

- ___ Arthralgia
- ___ Chills
- ___ Cough
- ___ Dyspnea
- ___ Fever
- ___ Headache
- ___ Hives
- ___ Malaise/fatigue
- ___ Myalgia
- ___ Nasal congestion
- ___ Pain/soreness at injection site
- ___ Rash, generalized
- ___ Rash, localized
- ___ Rhinorrhea
- ___ Sore throat
- ___ Swelling
- ___ Others (specify): _____

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: _____

* Work address: _____

* City: _____ * State: _____ * Zip code: _____

* Title: _____

Custom

Label		Label	
_____	___/___/___	_____	___/___/___
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments