



### Healthcare Worker Influenza Vaccination

\* Required for saving

\*\* Required for completion

\*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®  
\_\_\_\_ FluLaval®

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

\* 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-79, Atlanta, GA 30333, ATTN: PRA (0920-0666).

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

\*\*If YES, select all that apply.

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

\* Work address: \_\_\_\_\_

\* City: \_\_\_\_\_ \* State: \_\_\_\_\_ \* Zip code: \_\_\_\_\_

\* Title: \_\_\_\_\_

**Custom**

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

**Comments**