



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