OMB No. xxxx-xxxx
Exp. Date: xx-xx-20xx

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.**

* Adverse reaction to vaccine: ___ Y ___ N ___ Don't know
**If YES, select all that apply.

___ Arthralgia
* ___ Chills
___ Cough
___ Dypsnea
___ 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