

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:

Non-seasonal:

Afluria®

2009 H1N1: CSL Limited

Agriflu®

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 |
|---------------------|---------------------|
| _____ / ____ / ____ | _____ / ____ / ____ |
| _____ | _____ |
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Comments