Patient Vaccination

OMB No. 0920-0666
Exp. Date: 09-30-2012

* required for saving
^ conditionally required

*Facility ID:	*Event #:
*Patient ID:	Social Security #:
Secondary ID:	
Patient Name, Last:	First: Middle:
*Gender: F M Other	*Date of Birth:
Ethnicity (specify):	Race (specify):
*Event Type: FLUVAX	
*Influenza subtype: ☐ Seasonal ☐ Non-Seasonal	*Date Admitted to Facility:
*Vaccine offered: ☐ Yes ☐ No	*Vaccine declined: ☐ Yes ☐ No

Reason(s) vaccine declined (Check either section A or B but not both)

A. Medical contraindication(s) (check all that apply):

☐ Allergy to vaccine components

☐ History of Guillian-Barre syndrome within 6 weeks of previous influenza vaccination

☐ Current febrile illness (Temp > 101.5°F)

☐ Other (specify): _____

B. Personal reason(s) for declining (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): _____

***Vaccine administered: ☐ Yes ☐ No**

^Date Vaccine Administered:

^Type of influenza vaccine administered:

Seasonal: ☐ Afluria® ☐ Agriflu ® ☐ Fluarix® ☐ FluLaval® ☐ Flumist®
☐ Fluvirin® ☐ Fluzone® ☐ Fluzone High-Dose® ☐ Other (specify) _____

Non-seasonal: ☐ Other (specify) _____

☐ Live attenuated influenza vaccine (LAIV) e.g., nasal ☐ Inactivated vaccine (TIV)

^Manufacturer: _____ ^Lot number: _____

^Route of administration: ☐ Intramuscular ☐ Intranasal ☐ Subcutaneous

Vaccine Information Statement (VIS) Provided to Patient:

☐ Live Attenuated Influenza VIS ☐ Inactivated Influenza VIS ☐ None or unknown

Edition Date: _____/_____/_____

Person Administering Vaccine:

Vaccinator ID: Title:

Name: Last: First: Middle:

Work Address: _____

City:_____ State: _____ Zip code: _____

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Custom Fields

Label		Label	
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Comments