Healthcare Worker Influenza Vaccination

OMB No. 0920-0666
Exp. Date: xx-xx-xxxx

* Required for vaccines that are administered ONSITE.

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:
- ☐ Afluria®
- ☐ Agriflu®
- ☐ Fluarix®
- ☐ Flulaval®
- ☐ Flumist®
- ☐ Fluvirin®
- ☐ Fluzone®

Non-seasonal:
2009 H1N1: ☐ CSL Limited
- ☐ Novartis and Diagnostics, Ltd.
- ☐ Sanofi Pasteur, Inc.
- ☐ MedImmune LLC

Other (please specify)_____

*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:

- ☐ Arthralgia
- ☐ Chills
- ☐ Cough
- ☐ Fever
- ☐ Headache
- ☐ Hives
- ☐ Malaise/fatigue
- ☐ Myalgia
- ☐ Nasal congestion
- ☐ Pain/soreness at injection site
- ☐ Rash, generalized
- ☐ Rash, localized
- ☐ Rhinorrhea
- ☐ Shortness of breath/difficulty breathing
- ☐ Sore throat
- ☐ Swelling
- ☐ Other (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: _____

Title: _____

Work address: _____

City: _____ State: _____ Zip code: _____

Custom Fields

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