

* 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: <input type="checkbox"/> Seasonal <input type="checkbox"/> Non-Seasonal	*Date Admitted to Facility:
*Vaccine offered: <input type="checkbox"/> Yes <input type="checkbox"/> No	*Vaccine declined: <input type="checkbox"/> Yes <input type="checkbox"/> No

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

<p>A. Medical contraindication(s) (check all that apply):</p> <p><input type="checkbox"/> Allergy to vaccine components</p> <p><input type="checkbox"/> History of Guillian-Barre syndrome within 6 weeks of previous influenza vaccination</p> <p><input type="checkbox"/> Current febrile illness (Temp > 101.5°F)</p> <p><input type="checkbox"/> Other (specify): _____</p>	<p>B. Personal reason(s) for declining (check all that apply):</p> <p><input type="checkbox"/> Fear of needles/injections</p> <p><input type="checkbox"/> Fear of side effects</p> <p><input type="checkbox"/> Perceived ineffectiveness of vaccine</p> <p><input type="checkbox"/> Religious or philosophical objections</p> <p><input type="checkbox"/> Concern for transmitting vaccine virus to contacts</p> <p><input type="checkbox"/> Other (specify): _____</p>
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*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: _____

Assurance of Confidentiality: The voluntarily provided 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)).

Patient Vaccination

Custom Fields

Label

_____	__/__/__
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Label

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Comments