OMB No. 0920-0666
Exp. Date: xx-xx-xxxx
www.cdc.gov/nhsn

Patient Vaccination

* required for saving
^ conditionally required

*Facility ID:	*Event #:
*Patient ID:	Social Security #:
Secondary ID:	Medicare #:
Patient Name, Last: First:	Middle:
*Gender: M F 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)	B. Personal reason(s) for declining (check all that apply):
☐ Allergy to vaccine components	☐ Fear of needles/injections
☐ History of Guillian-Barre syndrome within 6 weeks of previous influenza vaccination	☐ Fear of side effects
☐ Current febrile illness (Temp > 101.5°F)	☐ Perceived ineffectiveness of vaccine
☐ Other (specify): _____	☐ 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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Patient Vaccination

Custom Fields

Label		Label	
_____	____/____/____	_____	____/____/____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments