

Exp. Date: xx-xx-xxxx www.cdc.gov/nhsn

Patient Vaccination

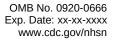
* required for saving conditionally required

OMB No. 0920-0666

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*Facility ID:	*Event #:			
*Patient ID:	Social Security #:			
Secondary ID:	Medicare #:			
Patient Name, Last: First:	Middle:			
*Gender: M F Other Ethnicity (Specify):	*Date of Birth:			
*Event Type: FLUVAX	Race (Specify):			
	*Data Admitted to Facility			
*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)	\square Perceived ineffectiveness of vaccine			
Other (specify):	\square Religious or philosophical objections			
	\square 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® ☐Fluz	one High-Dose®			
Non-seasonal: Other (specify):				
Live attenuated influenza vaccine (LAIV) e.g., nasal				
^Manufacturer: ^Lot number:				
^Route of administration:	☐ 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)).				
Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information				

unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666).

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