

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:

Non-seasonal:

Afluria®

2009 H1N1: CSL Limited

Agriflu®

Fluarix®

Novartis and Diagnostics, Ltd.

Flulaval®

Sanofi Pasteur, Inc.

Flumist®

MedImmune LLC

Fluvirin®

Other (please specify) _____

Fluzone®

*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

