

# Patient Vaccination

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\* 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: <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)			
A. Medical contraindication(s) (check all that apply)		B. Personal reason(s) for declining (check all that apply):	
<input type="checkbox"/> Allergy to vaccine components <input type="checkbox"/> History of Guillian-Barre syndrome within 6 weeks of previous influenza vaccination <input type="checkbox"/> Current febrile illness (Temp > 101.5°F) <input type="checkbox"/> Other (specify): _____		<input type="checkbox"/> Fear of needles/injections <input type="checkbox"/> Fear of side effects <input type="checkbox"/> Perceived ineffectiveness of vaccine <input type="checkbox"/> Religious or philosophical objections <input type="checkbox"/> Concern for transmitting vaccine virus to contacts <input type="checkbox"/> Other (specify): _____	
*Vaccine administered: <input type="checkbox"/> Yes <input type="checkbox"/> No			
^Date Vaccine Administered:			
^Type of influenza vaccine administered:			
Seasonal: <input type="checkbox"/> Afluria® <input type="checkbox"/> Agriflu® <input type="checkbox"/> Fluarix® <input type="checkbox"/> FluLaval® <input type="checkbox"/> Flumist® <input type="checkbox"/> Fluvirin® <input type="checkbox"/> Fluzone® <input type="checkbox"/> Fluzone High-Dose® <input type="checkbox"/> Other (Specify): _____			
Non-seasonal: <input type="checkbox"/> Other (specify): _____			
<input type="checkbox"/> Live attenuated influenza vaccine (LAIV) e.g., nasal		<input type="checkbox"/> Inactivated vaccine (TIV)	
^Manufacturer: _____		^Lot number: _____	
^Route of administration: <input type="checkbox"/> Intramuscular <input type="checkbox"/> Intranasal <input type="checkbox"/> Subcutaneous			
Vaccine Information Statement (VIS) Provided to Patient:			
<input type="checkbox"/> Live Attenuated Influenza VIS <input type="checkbox"/> Inactivated Influenza VIS <input type="checkbox"/> None or unknown Edition Date: ____/____/____			
Person Administering Vaccine:			
Vaccinator ID:		Title:	
Name: Last:		First:	Middle:
Work Address: _____			
City: _____		State: _____	Zip Code: _____
<small>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)).</small>			
<small>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).</small>			
CDC 57.133 rev 4, v 6.6			

