



Influenza Vaccination Standing Orders

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*required for saving
^conditionally required

*Facility ID:			
DO NOT VACCINATE (Check one)		(*Imprint patient information or place patient label here)	
<input type="checkbox"/> Patient is less than 6 months old. <input type="checkbox"/> Patient has been previously vaccinated.			
*Vaccine offered: <input type="checkbox"/> Yes <input type="checkbox"/> No		^Influenza Subtype: <input type="checkbox"/> Seasonal <input type="checkbox"/> Non-seasonal	*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): <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): _____		B. Personal reason(s) for declining (check all that apply): <input type="checkbox"/> Previously vaccinated this season <input type="checkbox"/> Fear of needs/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): _____	
*Orders: <input type="checkbox"/> Vaccinate <input type="checkbox"/> Do NOT vaccinate <input type="checkbox"/> Standing order – no signature required			
^Physician signature:			
*Vaccine administered: <input type="checkbox"/> Yes <input type="checkbox"/> No		^Date 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"/> Fluzone Intradermal® <input type="checkbox"/> Other (specify): _____			
Non-seasonal: <input type="checkbox"/> Other (specify): _____			
<input type="checkbox"/> Live attenuated influenza vaccine (LAIV) e.g., nasal ^Manufacturer: _____		<input type="checkbox"/> Inactivated vaccine (TIV) ^Lot number: _____	
^Route of administration: <input type="checkbox"/> Intradermal <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 <input type="checkbox"/> Unknown Edition Date: _____ / _____ / _____ Vaccine ID of Person Administering Vaccine: _____ 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)). CDC 57.134 v6.6			