



# Healthcare Worker Influenza Vaccination

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\*required for vaccines that are administered ONSITE.

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:   |
| <input type="checkbox"/> Afluria®  | 2009 H1N1: <input type="checkbox"/> CSL Limited         |
| <input type="checkbox"/> Agriflu®  |   |
| <input type="checkbox"/> Fluarix®  | <input type="checkbox"/> Novartis and Diagnostics, Ltd. |
| <input type="checkbox"/> Flulaval® | <input type="checkbox"/> Sanofi Pasteur, Inc.           |
| <input type="checkbox"/> Flumist®  | <input type="checkbox"/> MedImmune LLC                  |
| <input type="checkbox"/> Fluvirin® | Other (please specify): _____                           |
| <input type="checkbox"/> 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

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CDC 57.209 (Front) rev.3, v6.6



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### Event Details (cont.)

\*Adverse reaction to vaccine:     Yes     No     Don't know

If Yes, check all that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Arthralgia       | <input type="checkbox"/> Pain/soreness at injection site          |
| <input type="checkbox"/> Chills           | <input type="checkbox"/> Rash, generalized                        |
| <input type="checkbox"/> Cough            | <input type="checkbox"/> Rash, localized                          |
| <input type="checkbox"/> Fever            | <input type="checkbox"/> Rhinorrhea                               |
| <input type="checkbox"/> Headache         | <input type="checkbox"/> Shortness of breath/difficulty breathing |
| <input type="checkbox"/> Hives            | <input type="checkbox"/> Sore throat                              |
| <input type="checkbox"/> Malaise/fatigue  | <input type="checkbox"/> Swelling                                 |
| <input type="checkbox"/> Myalgia          | <input type="checkbox"/> Other (specify): _____                   |
| <input type="checkbox"/> Nasal congestion |   |

Which vaccine information statement, including edition date, was provided to the vaccinee?

- Live Attenuated Influenza Vaccine Information Statement  
 Inactivated Influenza Vaccine Information Statement

Edition date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (mm/dd/yyyy)

### Person Administering Vaccine

Vaccinator ID: \_\_\_\_\_ (This is the HCW ID # for the vaccinator)  
 Name, Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
 Title: \_\_\_\_\_  
 Work address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

### Custom Fields

Label	Label
_____ / ____ / ____	_____ / ____ / ____
_____	_____
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### Comments