

# Flu Vaccine Reporting Form

Clinic name:

Clinic ID:

Phone number:

Report influenza vaccines on this reporting form. All other vaccines are reported with a separate form. Use "Other" if the vaccine administered is not listed. Fax to 215-238-6944 or email completed form to [philavax@phila.gov](mailto:philavax@phila.gov).

|                                                                                                                                                                                                                                                                                                                                                                                                                                                 |       |                |            |            |                   |             |           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|----------------|------------|------------|-------------------|-------------|-----------|
| Vaccination Date:                                                                                                                                                                                                                                                                                                                                                                                                                               |       | Date of Birth: |            | Last Name: |                   | First Name: |           |
| Address:                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |                | City:      |            | State:            |             | ZIP Code: |
| Sex:                                                                                                                                                                                                                                                                                                                                                                                                                                            | Race: |                | Ethnicity: |            | Patient Language: |             |           |
| Email:                                                                                                                                                                                                                                                                                                                                                                                                                                          |       |                |            |            | Phone Number:     |             |           |
| <b>Patient VFC/VFAAR Eligibility (Check one):</b><br><div> <div>Uninsured</div> <div>Underinsured</div> <div>American Indian or Alaskan Native</div> <div>Enrolled in Medicare</div> <div>Enrolled in Medicare</div> <div>CHIP</div> <div>317 VFAAR</div> <div>Non VFC-Eligible</div> </div>                                                                                                                                                    |       |                |            |            |                   |             |           |
| <b>*Administration Site Abbreviations:</b><br><div> <div>LPUA – Left Outer Aspect Upper Arm</div> <div>LD – Left Deltoid</div> <div>LALT – Left Anterior Lateral Thigh</div> <div>LVL – Left Vastus Lateralis</div> <div>PO – Orally</div> <div>RPUA – Right Outer Aspect Upper Arm</div> <div>RD – Right Deltoid</div> <div>RALT – Right Anterior Lateral Thigh</div> <div>RVL – Right Vastus Lateralis</div> <div>N – Intranasal</div> </div> |       |                |            |            |                   |             |           |

| Vaccine                       | Brand Name                  | Manufacturer    | Lot # | Vax Expiration Date | Dose (mL) | Admin. Site* |
|-------------------------------|-----------------------------|-----------------|-------|---------------------|-----------|--------------|
| IIV3 (Multi-dose vial)        | Fluzone (6-35 mo)           | Sanofi          |       |                     |           |              |
|                               | Fluzone (6 mo+)             | Sanofi          |       |                     |           |              |
|                               | Afluria (6-35 mo)           | Sanofi          |       |                     |           |              |
|                               | Afluria (3 yrs+)            | Seqirus         |       |                     |           |              |
|                               | Flucelvax (6 mo+)           | Seqirus         |       |                     |           |              |
| IIV3<br>(Single-dose syringe) | Fluarix (6 mo+)             | GlaxoSmithKline |       |                     |           |              |
|                               | FluLaval (6 mo+)            | GlaxoSmithKline |       |                     |           |              |
|                               | Fluzone (6 mo+)             | Sanofi          |       |                     |           |              |
|                               | Fluzone High Dose (65 yrs+) | Sanofi          |       |                     |           |              |
|                               | Afluria (3 yrs+)            | Seqirus         |       |                     |           |              |
|                               | Fluad (65 yrs+)             | Sanofi          |       |                     |           |              |
|                               | Flucelvax (2 years+)        | Seqirus         |       |                     |           |              |
| IIV3 (Single-dose vial)       | Fluzone (6 mo+)             | Sanofi          |       |                     |           |              |
| LAIV (Nasal spray)            | Flumist (2-49 yrs)          | AstraZeneca     |       |                     |           |              |
| RIV3 (Single-dose vial)       | Flublok (18 yrs+)           | Sanofi          |       |                     |           |              |
| Other                         |                             |                 |       |                     |           |              |