2018-2019 General State Funded Seasonal Influenza Vaccine Weekly Report

Please fax or email this report to SDIP every MONDAY by FAX: 619-692-6619 or Email: HHSA.CountyFluVaccine@sdcounty.ca.gov.

Organization & Site:	Vaccine Coordinator: _____ Tel: ( ) EXT:

Information on the Initial Doses Received (complete this 'Doses Received' section ONLY for the 1st weekly report)

Product Name	Flucelvax ccIIV4 (Multi-dose vials)	Fluarix IIV4 (PF Syringes)	FluLaval IIV4 (Multi-dose vials)	Flucelvax ccIIV4 (PF Syringes)
Date of initial doses received				
Number of initial doses received				

1. WEEKLY USAGE REPORT FROM: / / TO: / / (the week is Monday to Friday/Saturday)

Product Name-Fill in Lot #	Ages 6-35 months	Ages 3-6 years	Ages 7-18 years	Ages 19-49 years	Ages 50-59 years	Ages 60-64 years	Ages 65 + years	Total across
Flucelvax MDV-	N/A	>=4 yrs						
FluLaval MDV-	N/A							
Fluarix PF-								
Flucelvax PF-	N/A	>=4 yrs						

2. ACTUAL MANUAL COUNT OF STATE FLU INVENTORY DOSES AT THE END OF THE WEEK (the week is Monday-Friday/Saturday)

Previous Week's Manual Count	Product Name-Fill in Lot #	Number of Doses Currently on Hand	# of Wasted doses= W (# of Expired/ Disposed =D: at end of flu season)	Number of Extra Doses (MDVs only)
	Flucelvax MDV-			
	FluLaval MDV-			
	Fluarix PF-			N/A
	Flucelvax PF-			N/A

3. DID YOU TRANSFER, RECEIVE, OR RETURN STATE FLU VACCINES (RETURN TO ROSECRANS MEANS returning *UNOPENED* MDVs (MULTI-DOSE VIALS) OR *UNUSED* PF SYRINGES, DURING THE SAME WEEK OF THE REPORTING PERIOD?

■ NO □ YES, please fill out the vaccine information in the section below:

Product Name & Lot #	# of Doses	Method	Date	Name of SITE vaccines transferred to, received from, or returned to HHSA Rosecrans)
		□**Transferred** to □**Received from** □**Returned** to HHSA		
		□**Transferred to** □**Received from** □**Returned to HHSA**		
		□**Transferred to** □**Received from** □**Returned to HHSA**		

4. DID YOU ENTER ALL ADMINISTERED STATE FLU VACCINES INTO SDIR DURING THE SAME WEEK OF REPORTING PERIOD? Check one:

□ Yes, Attach SDIR Vaccine Usage Report ▣ No (Attach EHR/VA Report) □ NO VACCINES GIVEN THIS WEEK

Submitted by (print your name):_____ Title: _____Date:_____

Signature: _____ Phone: (_____)_____