

**Pandemic H1N1 2009 Vaccination Session Report Form
For Medically at Risk Patients**

PLEASE COMPLETE FOR EACH IMMUNISATION SESSION

HOSPITAL NAME: _____ **Date:** ___/___/___

Address: _____

Vaccine	Manufacturer	Expiry Date	Batch No.

Total Number of Individuals Presenting for Vaccination	Number Vaccinated

Completed By: _____ **Date:** _____

To be completed daily on completion of vaccination session.

Please fax completed form to the HSE National Immunisation Office

Fax Number 01-8682943