

# INFLUENZA (FLU) VACCINE REGISTRATION / CONSENT FORM

Burlington County Health Department



Public Health  
Prevent. Promote. Protect.

Burlington County Health Department  
Health Starts Here



PLEASE PRINT CLEARLY

NAME (last, first)			
STREET	STATE	ZIP	
CITY	<input type="checkbox"/> TWIN	<input type="checkbox"/> TRIPLET	<input type="checkbox"/> QUADRUPLET
PHONE	BIRTH COUNTRY:		AGE
MEDICARE Part B # (Include all letters)		Additional Insurance	

Please Answer The Following Questions:	Yes	No	BCHD
1. Is the person to be vaccinated sick today?			
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?			
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?			
4. Has the person to be vaccinated ever had Guillain-Barre syndrome, or any other neurological or neuromuscular disorder?			
5. Is the person to be vaccinated younger than age 2?			
6. I have received information about the New Jersey Immunization Information System (NJIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history. I understand that the medical information in the NJIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.1 understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). There is no cost to participate in this program. Select 'Yes' to participate in this Program. Select 'No' if you do not want to participate in this program.			

- I have read or had explained to me by Burlington County Health Department (BCHD) staff the attached information about influenza and the influenza vaccine. I have an opportunity to ask questions about influenza and the vaccine which were answered to my satisfaction, and I am 18 years of age or older. I have been informed of the Notice of Privacy Practices.
- To my knowledge the individual on whose behalf I am signing is not allergic to chicken eggs or chicken egg products, or Thimerosal (*Merthiolate*) and have never been advised by their physician or other healthcare provider to not receive this vaccine.
- The individual on whose behalf I am signing is not allergic to Epinephrine (adrenalin) the drug used to counteract an allergic reaction to a flu shot. He/She is not allergic to latex. He/She does not currently have a fever or the symptoms of an acute infection. He/She has never suffered with Guillain-Barre Syndrome or any other neurological disorder.
- I understand that the recommended immunization is one injection/dose. I understand that receipt of the vaccine does not completely protect the individual on whose behalf I am signing against the flu or other illnesses that resemble the flu. I further understand that if the individual on whose behalf I am signing has a condition of (or is undergoing treatment which causes) immuno-suppression (the reduction in my body's ability to fight infection and illness), the effectiveness of the vaccine in preventing the flu may be diminished. I believe I understand the risks and benefits of the vaccine for the individual on whose behalf I am signing.
- I understand that it is my responsibility to remain in the vaccination area for 15 minutes after the individual on whose behalf I am signing receives the vaccine, in case he/she experiences a reaction.
- I agree for the individual on whose behalf I am signing to receive the influenza vaccine and I hereby release the Burlington County Board of Chosen Freeholders, County Health Department and their employees, servants, representatives, officers, and agents (together, the "Indemnities") from any liability for giving the individual on whose behalf I am signing the influenza vaccination. I agree to indemnify, defend, and hold the indemnities harmless from any claim made by any person, (including the individual on whose behalf I am signing). If Medicare Part B eligible, I authorize Burlington County to bill Medicare Part-B for the immunization and I authorize Medicare benefits to be paid directly to the Burlington County Health Department.
- My Signature on this form means that all of the information provided in this Application and Consent Form are true to the best of my knowledge. I understand that this form and my signature below are binding on me and my heirs, successors and personal and legal representatives as well as those of the person on whose behalf I am signing. If I am not the person being vaccinated, I warrant that I have the authority to give this consent for the person to be vaccinated.

Signature:

Date \_\_\_\_\_

OFFICIAL USE ONLY	
<b>Vaccination Site:</b> <input type="checkbox"/> Right Deltoid <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh	<b>Lot Number / Exp Date:</b> SANOFI PASTEUR INC FLUZONE Quadrivalent 5ML DS NDC 5-4-2: 49281-0629-15 Lot # U1998AE Expiration Date: 06/30/2019
<b>Clinic Location:</b> _____	<b>VIS Publication Date:</b> <u>8/7/2015</u> <b>Date Given:</b> _____
<b>Vaccine Administered by:</b> _____	<b>Date:</b> _____