ADULT INFLUENZA (FLU) VACCINE REGISTRATION / CONSENT FORM

Burlington County Health Department

PLEASE PRINT CLEARLY

NAME (last, first)			
STREET		STATE	ZIP
CITY	☐ TWIN ☐TRIPLET ☐QUADRUPLET		AGE
PHONE ☎	BIRTH COUNTRY:		DATE OF BIRTH
MEDICARE Part B # (Include all letters) (BRING YOUR MEDICARE CARD WITH YOU)	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, chicken, chicken egg products 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 allergic to any medication?			
6.	I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my immunizations are due and to keep a central record of my immunization history. I understand that the medical information in the NJIIS 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 I understand that I can get a copy of my 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 received the appropriate Centers for Disease Control and Prevention Vaccine Information Statement. I have had an opportunity to ask questions about influenza and the influenza vaccine which were answered to my satisfaction. I have been informed of the Notice of Privacy Practices.
- I have never been advised by my physician or other healthcare provider not to receive this vaccine.
- I am not allergic to latex. I do not currently have a fever or the symptoms of an acute infection.
- I understand that the recommended immunization is one injection/dose. I understand that receipt of the vaccine does not completely protect me against the flu or other illnesses that resemble the flu. I further understand that if I have a condition of (or am 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.
- If requested, I understand that it is my responsibility to remain in the vaccination area for 10-15 minutes after I receive the vaccine, in case I experience a reaction.
- I agree 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 me (or 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 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

Vaccination Site: ☐ Right Deltoid ☐ Left Deltoid

SANOFI PASTEUR, INC
FLUZONE QUADRIVALENT 5ML MDV
NDC 5-4-2: 49281-0633-15
LOT # UJ475AB
Expiration 6/30/2021

Clinic Location: _____ **VIS Publication Date:** 8/15/2019 **Date Given:**_____

Vaccine Administered by: _____ **Date**: _____