Public Health
Prevent. Promote. Protect.

Serving the Communities of Bloomfield, Caldwell, Chatham Township, Cranford, Glen Ridge, Madison, Mountain Lakes & Springfield

Seasonal Influenza Consent Form

Date _____

Name _____ Date of Birth _____ Sex _M / F__

Address _____ City _____ State ___NJ__ Zip_____

Phone _____ TYPE OF PAYMENT: Cash/Check _____

Medicare Number (include letter) _____ **NO HMO's/PPO's/Railroad Ins. Accepted**

Screening Questionnaire for Injectable Influenza Vaccine

1. Is the person to be vaccinated sick today?	YES	NO	DON'T KNOW
2. Does the person to be vaccinated have an allergy to latex, eggs or to a component of the vaccine? Other Components: gelatin thimerosal	YES	NO	DON'T KNOW
3. Has the person to be vaccinated ever had a serious reaction to flu vaccine in the past?	YES	NO	DON'T KNOW
4. Has the person to be vaccinated ever had Guillain-Barre syndrome?	YES	NO	DON'T KNOW

Completed by _____ (person receiving vaccine must initial) **Reviewed by _____ (nurse to initial)**

Consent & Release: I hereby give permission for the seasonal flu vaccine. I have been informed that if I have any questions regarding the nature of the vaccine, its expected benefits, its risks and alternative tests, I should ask those questions before I consent to the vaccine administration. I hereby release the Township of Bloomfield, Bloomfield Board of Health, Bloomfield Department of Health & Human Services, it's director, officers, physicians, nurses, agents, and all others involved in this vaccine administration from any and all liability, included but not limited to performance of the vaccine and failure to correctly discover and report to me results, and any failure to make correct recommendations. I understand that, by administering this vaccine, the Bloomfield Department of Health & Human Services is not assuming any responsibility for my care and/or diagnosis and treatment, and I have been advised to consult my personal health care provider if I have any questions concerning the vaccine. All information I have provided to the Bloomfield Department of Health & Human Services concerning my medical history is, to the best of my knowledge, complete, truthful and accurate.

Assignment of Benefits: I hereby authorize & request that payment of benefits by my insurance company be made directly to the Bloomfield Department of Health & Human Services for services furnished to me. I understand that I am responsible for all charges not covered by this assignment. The Bloomfield Department of Health & Human Services is acting in filing for insurance benefits assigned to them & can assume no responsibility for guaranteeing payment of any charges from the insurance company.

I have read & understand the Consent & Release and Assignment of Benefits stated above.

Signature of Patient/Parent/Guardian/Authorized Designee: _____

For Office Use Only:

Vaccine Site: Left deltoid Right deltoid RN Signature

_____

Manufacturer: Seqirus Lot # 1: P100362830 Expiration Date: 6/30/2022

Seqirus Lot #2: P100365584 Expiration Date: 6/30/2022