

INFLUENZA VACCINE (2008)

VACCINE ADMINISTRATION CONSENT RECORD

I have read or have had explained to me the information sheet provided to me about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request. **Flu Shots are Free for Cumberland County residents in our service area. There will be a \$20.00 charge for Vineland or Out of County Residents.**

Please circle your answers to the following questions:

- Are you allergic to chicken eggs or chicken products? ----- Yes or No
- Are you allergic to Thimerosal (a mercury based preservative)? ----- Yes or No
- Have you had a serious allergic reaction to a previous dose of influenza vaccine? Yes or No
- Do you have a history of Guillain-Barre Syndrome? ----- Yes or No
- Do you have a fever or are you presently ill? ----- Yes or No
- Are you Pregnant? ----- Yes or No
- Are you currently on blood thinner therapy or have excessive bleeding?
i.e. :(coumadin,heparin) ----- Yes or No

If so, you may consult your doctor for a Flu Shot.

Privacy Policy - I have seen and been informed of the Privacy Practices of the Cumberland County Department of Health, and I Authorize the Use and Disclosure of my Medical Information concerning this Influenza Immunization as per these practices.

The Cumberland County Health Department will keep this medical record on file. We will record what vaccine was given & other pertinent information about the vaccine. Immunizations of Children 6 mo. to 18 yrs will be registered on NJIIS.

Information about person to receive vaccine (Please Print)

_____	_____	_____	_____	<u>M</u> <u>F</u>
Last Name	First	MI	Birth date/Age	Sex

Address _____

_____	_____	_____	_____
City	State	ZIP	Telephone #

X _____
Signature/Person to receive vaccine or person authorized to make the request (parent or guardian)

FOR CLINIC/OFFICE USE

Clinic/Office Address: _____ Date Vaccine Administered: _____

Vaccine Lot Number _____ Exp. Date: _____ Sanofi Pasteur- Fluzone

Site of injection (circle one) **Left Deltoid** or **Right Deltoid** (**Infant- ant. thigh**) (BIOJECT Syringe # 3 , or 4 , or 5)
or
(Needle and Syringe)

Signature/Title of Vaccine Administrator _____