Board of Chosen Freeholders
Salem County Department of Health
856-935-7510, Ext. 8477 or 358-3857, Ext. 8477
SEASONAL INFLUENZA VACCINE (2009 - 2010)
VACCINE ADMINISTRATION RECORD

The Salem County Department of Health will keep this medical record on file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given.

"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 to the person named below for whom I am authorized to make this request."

Please circle your answers to the following questions:

Are you currently taking medication to thin your blood? Aspirin, Coumadin, Heparin, etc. **Yes or No**

Are you allergic to eggs? **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? (neuro-muscular disorder) **Yes or No**

Do you have a fever or are you presently ill? **Yes or No**

***Privacy Policy* – I have seen and been informed of the Privacy Practices of the Salem County Health Department, and I authorize the use and disclosure of my Medical Information concerning the Influenza Immunization as per these practices.**

I release the Salem County Department of Health, and the officers, directors, agents, contractors and employees of this organization from any liability whatsoever arising out of the immunization.

Municipality_____ ☐ ***$25 dollar fee for out of county residents***

_____ _____ M F

Last Name First MI Birth date/Age Sex

_____

Address City State ZIP County

X _____ Telephone # _____

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

Clinic/Office Address: Salem County Health Department, 98 Market Street, Salem, NJ 08079

Site of injection: ____ Left Deltoid _____ Right Deltoid _____ Other _____ Bioject _____ Syringe

Signature/Title of Vaccine Administrator _____

Date/Place Vaccine administered:
Exp. Date: expires