



Cape May County Flu Clinic 2017-18 Patient Consent Form

Name: _____ DOB: ___/___/___ Age: _____ Sex: Male Female

Home Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Print Guardians Name(if under 18yo.): _____

Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	Race: <input type="checkbox"/> White <input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian <input type="checkbox"/> Other	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native
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Are you a healthcare worker or do you work in a long-term care facility? Yes No
 Do you live with or take care of someone who is at high risk for influenza complications? Yes No
 Did you get a flu vaccine last year? Yes No

Health Insurance:

- Private insurance
- Medicaid or NJ FamilyCare insurance (through the State – select type below)
 - Amerigroup Horizon NJ Health United Healthcare Healthfirst
- Uninsured

VACCINE SCREENING QUESTIONS:	Yes	No	
Do you have a severe allergy to eggs or other vaccine component?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, you must receive the flu vaccine from your doctor
Have you been diagnosed with Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a severe allergy to Thimerosal?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, you cannot receive the vaccine at the drive-through clinic
Have you received other vaccines in past month?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, specify:
Have you ever had a serious reaction to a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a severe allergy to latex?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, speak with the nurse
Do you have a fever today?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, wait to get vaccinated

I am electing to receive a vaccination against influenza. I am taking this vaccine voluntarily and consent to the vaccination being given to me. I have read the Vaccine information Statement (8/07/15). I understand the risks and benefits of this vaccine. I have had an opportunity to ask questions which have been answered to my satisfaction. I hereby waive any claim for damages that I or anyone claiming on my behalf may have against the County, Health Department, clinic, employees and/or agents on account of any injury or misfortune I may suffer as a result of this vaccination. I further understand information may be entered into the New Jersey Immunization Information System.

Today's Date ___/___/___ Patient Signature _____
 (Parental signature required if less than 18 years)

Medical staff use only: Site: <input type="checkbox"/> RD <input type="checkbox"/> LD	GSK/Sanofi/Seqirus
Vaccinator Signature:	Affix sticker here

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