CLIFTON HEALTH DEPARTMENT

900 Clifton Ave., Clifton, NJ 07013
(973) 470-5760

ADULT INFLUENZA CONSENT FORM

NAME (please print) _____ **MALE ( ) FEMALE ( )**

ADDRESS: _____ **CITY:** _____ **ZIP:** _____

PHONE #: _____ **BIRTHDATE:** _____/_____/_____ **AGE :** _____

(If City Employee) Department: _____ (If School Employee) School: _____

MEDICARE PATIENTS ONLY **(please keep your Medicare card out to be copied)**

MEDICARE NUMBER _____

DO YOU HAVE A **MEDICARE HMO** AS YOUR PRIMARY INSURANCE? YES ( ) NO ( )
IF YES, YOU NEED TO PAY $20.00

RELATIONSHIP TO INSURED: SELF ( ) SPOUSE ( ) DEPENDENT ( )

If applicable: " I request that payment of authorized Medicare benefits be made to the Clifton Health Department for any services furnished to me by the agency, the Clifton Health Department agrees to accept the Medicare reimbursement as payment in full. I authorize any holder of medical information about me to release to the Health Care Financial Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

EVERYONE MUST ANSWER ALL QUESTIONS:

1. Are you sick today? Yes ( ) No ( )
2. Are you allergic to eggs or to a component of the vaccine? Yes ( ) No ( )
3. Have you ever had a serious reaction to influenza vaccine in the past? Yes ( ) No ( )
4. Have you ever had Guillain-Barre Syndrome? Yes ( ) No ( )
5. Are you pregnant? Yes ( ) No ( )

If "yes", a prescription from your obstetrician must be presented prior to receiving vaccine.

I have read the **information on influenza vaccine** and have had any and all questions answered. I understand the benefits and risks of the vaccines as described. I hereby consent to the administration of the influenza vaccine. I hereby release the Clifton Health Department, the City of Clifton and/or its employees and/or agents from any and all liability arising from any services rendered by, or on behalf of the Clifton Health Department.

Signature: _____ **Date:** _____

FOR CLINIC USE ONLY

DATE ADMINISTERED: _____ INJECTION SITE

☐ **Quadrivalent** Lot # / Exp. 02144611A / 5/30/2019 Seqirus ☐ Right deltoid

☐ **High Dose Trivalent** Lot # / Exp. _____ Sanofi Pasteur ☐ Left deltoid

Administered By: _____

Date VIS Published 8/7/15 42 U.S.C. § 300aa-26 Date VIS Given_____

The Clifton Health Department is a contractual health agency serving the Township of Little Falls.