



Public Health  
Prevent. Promote. Protect.

# CLIFTON HEALTH DEPARTMENT

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

## CHILD INFLUENZA CONSENT FORM (6 months through 18)

NAME (please print) \_\_\_\_\_ MALE ( ) FEMALE ( )

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE #: \_\_\_\_\_ BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_

To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the VFC program, at each immunization encounter/visit, **enter the date and initial the appropriate eligibility category:**

DATE	ELIGIBLE for VFC Vaccine				NOT ELIGIBLE for VFC Vaccine	
	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	Underinsured must be vaccinated at a FQHC	Has health insurance that covers vaccines	Enrolled in CHIP (NJ FamilyCare Plan B, C or D)

**EVERYONE MUST ANSWER ALL QUESTIONS:**

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

I have read the **information on influenza vaccine** and have had any and all questions answered. I understand the benefits and risks of the vaccine as described. I hereby consent to the administration of the influenza vaccine to the person named above. 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.

Parent Name (printed): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**FOR CLINIC USE ONLY**

DATE ADMINISTERED: \_\_\_\_\_

INJECTION SITE

Quadrivalent

Manufacturer:

R Deltoid

R Thigh

0.25cc (6-35-mos)

Lot # / Exp.

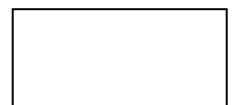
L Deltoid

L Thigh

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.*