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:** _____

FOR CLINIC USE ONLY

DATE ADMINISTERED:_____ INJECTION SITE

Quadrivalent ☐ 0.25cc (6-35-mos)

Manufacturer:

Lot # / Exp.

☐ R Deltoid ☐ R Thigh

☐ 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.