Ocean County Health Department
P.O. Box 2191
Toms River, New Jersey 08754-2191

Influenza Vaccination Consent Form

Please Print: Date of Birth: ____/____/____ Gender: ☐ Female ☐ Male

Name: First **Last**

Address: _____

City: _____ State: _____ Zip: _____ Phone Number:_____

1. Has the person ever received the flu vaccine before? ☐ Yes ☐ No
2. Has this person ever had a severe allergic reaction to the flu vaccine or eggs? ☐ Yes ☐ No
3. Does the person receiving the vaccine have a fever of ≥100 degrees F? ☐ Yes ☐ No
4. Does the person receiving the vaccine have a history of Guillain-Barré syndrome? ☐ Yes ☐ No
5. For child 6 mo-8 yrs, have they received 2 or more doses of influenza vaccine since July 2010? ☐ Yes ☐ No
   (If no, the child will need to receive 2 vaccinations [at least one month apart] for the best protection against flu.)

Parent/Guardian Name: _____ Relationship to Child: _____

I have read, or have had explained to me, the CDC Vaccine Information Statement about influenza and the influenza vaccine. I acknowledge that I have been given the opportunity to review the OCHD Notice of Privacy Practices on this date. I understand that this vaccine may cause flu-like symptoms in some people but will not actually cause the flu. I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to me or the person named above for whom I am authorized to make this request. I have answered all questions truthfully and accurately. I request that payment of authorized Medicare benefits be made to me or on my behalf to the Ocean County Health Department for any services furnished to me by the OCHD. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

Medicare Number * Exactly as it appears on Medicare Card

_____

Date of Vaccination: ☐☐ / ☐☐ / ☐☐

DO NOT WRITE IN THIS SPACE—OFFICE USE ONLY

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	SITE	Vaccine Lot #/Exp
☐ Fluzone Quadrivalent- 6 months & older	R / L Deltoid- IM	
	R / L Ant-Lateral Thigh- IM	
☐ Fluzone High Dose Quadrivalent- 65 years & older	R / L Deltoid- IM	
☐ Flublok Quadrivalent Egg Free- 18 years & older	R / L Deltoid- IM	

_____ _____

Signature of Nurse: **Date:**

8/2020