Cape May County Flu Clinic
2023-2024 Patient Consent Form

Name:_____ DOB: ____/____/_____ Age:_____ Sex: ☐Male ☐Female

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

Telephone: _____

Print Guardians Name (if under 18 yr.) _____

Are you a healthcare worker or work in a long-term care facility?(Provide vaccination proof) ☐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

VACCINE SCREENING QUESTIONS:	**Yes**	**No**	
Do you have a severe allergy to eggs or other vaccine components?	☐	☐	**If YES, you must receive the flu vaccine from your doctor**
Have you been diagnosed with Guillain-Barré syndrome?	☐	☐	
Do you have a severe allergy to Thimerosal?	☐	☐	**If YES, Specify:**
Have you ever had a serious reaction to a flu vaccine?	☐	☐	**If YES, Specify:**
Do you have a severe allergy to latex?	☐	☐	**If YES, speak with the nurse**
Do you feel sick today?	☐	☐	**If YES, speak with the nurse**

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 (8/06/21). 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)

Today's Date___/___/_____ **Vaccine Administrator Signature**_____

Medical staff use only: Site: ☐ RD ☐ LD ☐ RT ☐ LT	GSK/Sanofi/Seqirus
	Affix Sticker Here

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