Cape May County Flu Clinic
2019-2020 Patient Consent Form

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

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

Telephone: _____ Print Guardians Name (if under 18yo.):_____

Ethnicity:	**Race:**		
☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ White ☐ Black or African American	☐ Asian ☐ Other	☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaskan Native

Are you a healthcare worker or do you work in a long-term care facility? ☐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

Health Insurance:

☐ Private insurance

☐ Medicaid or NJ FamilyCare insurance (through the State – select type below)

☐Amerigroup ☐Horizon NJ Health ☐United Healthcare ☐Healthfirst

☐ Uninsured

VACCINE SCREENING QUESTIONS:	Yes	No	
Do you have a severe allergy to eggs or other vaccine component?	☐	☐	**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?	☐	☐	
Have you received other vaccines in past month?	☐	☐	**If YES, specify:**
Have you ever had a serious reaction to a flu vaccine?	☐	☐	
Do you have a severe allergy to latex?	☐	☐	**If YES, speak with the nurse**
Do you have a fever today?	☐	☐	**If YES, wait to get vaccinated**

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 (8/15/19). 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)

Medical staff use only: Site: ☐ RD ☐ LD	GSK/Sanofi/Seqirus
Affix sticker here	Affix sticker here

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Cape May County Department of Health

Keeping Cape May County Healthy