Cape May County Flu Clinic
2020-2021 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 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

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?	☐	☐	**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**
Have you come into close contact with someone who tested positive for COVID-19 in the past 15 days?	☐	☐	**If YES, speak with the nurse**
Have you traveled outside New Jersey in the past 14 days?	☐	☐	**If YES, speak with the nurse**
Did you have one of the following symptoms in the past 48 hours? • Fever or chills • Cough • Shortness of breath or difficulty breathing • Fatigue • Muscle or body aches • Headache • New loss of taste or smell • Sore throat • Congestion or runny nose • Nausea or vomiting • Diarrhea	☐	☐	**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 (8/15/19). 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)

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

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

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