



Cape May County Flu Clinic 2021-2022 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?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, you must receive the flu vaccine from your doctor
Have you been diagnosed with Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a severe allergy to Thimerosal?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, Specify:
Have you ever had a serious reaction to a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, Specify:
Do you have a severe allergy to latex?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, speak with the nurse
Have you come into close contact with someone who tested positive for COVID-19 in the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, speak with the nurse
Do you feel sick?	<input type="checkbox"/>	<input type="checkbox"/>	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: <input type="checkbox"/> RD <input type="checkbox"/> LD	GSK/Sanofi/Seqirus
<div style="border: 1px dashed black; display: inline-block; padding: 5px 20px;">Affix sticker here</div>	

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