



# Cape May County Flu Clinic 2021-2022 Employee Consent Form

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

County Department or Partnering Agency: \_\_\_\_\_

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 \_\_\_\_\_

<b>Medical staff use only:</b> 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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**Cape May County Department of Health**  
*Keeping Cape May County Healthy*