Ewing Township

2 Jake Garzio Drive Ewing NJ 08628 609-883-2900 ext 7619

Adult Influenza Registration Form 2019-2020

Write with ink only

Name:		Birth date:______________ Age: ____________
Address:		Apt:
City:	State: Zip:	Phone ( )
☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	

Insurance Information			
Are you currently **Insured**?	Yes No	Are you currently **employed**?	Yes No
PRIMARY **Card Holder's** Name:		**Card Holder's** Birth Date:	
Type of insurance: Medicare AARP AETNA Ameri Health NJ Direct Horizon BCBS Cigna Other			
ID Number & letters:		Group number:	

Please circle answer					
Do you have an allergy to ANY medications? List medication?	Y	N	Are you pregnant or breast feeding?	Y	N
			Do you have Asthma, or pulmonary disease?	Y	N
Are you allergic to **Latex**?	Y	N	Are you immunosuppressed (low WBC's)?	Y	N
Are you allergic to **eggs** or egg products?	Y	N	Are you taking steroids (oral or IV)?	Y	N
Have you had a reaction to the flu vaccine?	Y	N	Are you on Chemotherapy?	Y	N
Are you currently Ill? Do you have a cough, fever, sneezing, head cold?	Y	N	Are you allergic to Thimerosal (preservative) or Neomycin?	Y	N
Do you have a chronic illness? High BP High Cholesterol, Diabetes, Cancer, COPD	Y	N	Have you ever had **Guillain-Barre** Syndrome? Other:	Y	N

INFLUENZA CONSENT

I understand the benefits and risks of Influenza vaccine and I request that it be given to me or to the person named above who I am the parent, guardian or authorized person. My signature indicates that I understand that my information will remain confidential. If applicable, I give permission to bill Medicare or Insurance for eligible benefits. **I understand that there will be no charge if Medicare doesn't pay. Signature___________________________________**

Vaccine	Date vaccine a	Vaccinator	Site	Vaccine Lot #	Exp	Mfr	Date of VIS	VIS given	Patient Signature
High Dose	/ /19					AVP	8/15/2019	/ /19	

Cosignature ___________________________