Ewing Township

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

Adult Influenza Registration Form 2023-2024

Write with ink only

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

PRIMARY Insurance Information

Are you currently **Insured**?	Yes ☐ No ☐
Are you currently employed?	Yes ☐ No ☐
PRIMARY Card Holder's Name:	
Primary Card Holders Date of birth:	

Type of insurance: **(circle)**

Medicare ☐ AARP ☐ AETNA ☐ Ameri Health ☐ Cigna ☐

NJ Direct ☐ Horizon Blue Cross Blue Shield (BCBS) ☐ United ☐

Other:

ID Number & letters:

Group number:

SECONDARY Insurance Information

Do you have **SECONDARY** Insurance?	Yes ☐ No ☐
Is the **SECONDARY** card holder employed?	Yes ☐ No ☐
Secondary Insurance Card Holder's Name:	
Secondary Card Holder's Date of Birth:	

Type of insurance: **(circle)**

Medicare ☐ AARP ☐ AETNA ☐ Ameri Health ☐ Cigna ☐

NJ Direct ☐ Horizon Blue cross Blue shield (BCBS) ☐ United ☐

Other:

ID Number & letters:

Group number:

Please check the answer	Yes	No
Do you have an allergy to any medications? List medication?	☐	☐
Are you allergic to **Latex**?	☐	☐
Are you allergic to **eggs** or egg products?	☐	☐
Have you had a reaction to the flu vaccine?	☐	☐
Are you currently Ill with a cough, fever, sneezing, or a head cold?	☐	☐
Do you have a chronic illness? High Blood Pressure High Cholesterol, Diabetes, Cancer, COPD	☐	☐
Do you have Asthma, or pulmonary disease?	☐	☐
Are you pregnant or breastfeeding?	☐	☐
Are you immunosuppressed (low WBC's)?	☐	☐
Are you taking steroids (oral or IV)?	☐	☐
Are you on Chemotherapy?	☐	☐
Are you allergic to Thimerosal (preservative) or Neomycin?	☐	☐
Have you ever had **Guillain-Barre** Syndrome?	☐	☐

INFLUENZA CONSENT

I understand the benefits and risks of the 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_____ **Date**_____

VIS: Date Published 8/6/2021	Date VIS given:	Initial for VIS receipt:

Official Use Only

Vaccine: Regular Fluzone – High Dose Fluzone	Date vaccine given:	Site: Left arm Right arm
Vaccinator signature:	Co-signature:	

Place sticker here