Adult Inflenza Vaccine
Registration and Consent Form
Ewing Township Health Department

Public Health
Prevent. Promote. Protect.

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? ☐ Y ☐ N List medication?	Are you pregnant or breast feeding? ☐ Y N ☐
	Do you have Asthma, or pulmonary disease ☐ Y N ☐
Are you allergic or sensitive 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 any vaccines? ☐ Y ☐ N	Are you on Chemotherapy? ☐ Y N ☐
Are you currently Ill? (cough, fever, sneezing) ☐ Y ☐ N	Are you allergic or react to Thimerosal, (preservative), Yeast or Neomycin? ☐ Y N ☐
Do you have a chronic illness? ☐ Y ☐ N High BP, High Cholesterol, Diabetes, Cancer, COPD	Have you ever had **Guillain-Barre** Syndrom ☐ Y N ☐ Have you had any vaccinations in the past 3-4 weeks? 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 or insurance doesn't pay.
Signature_____

OFFICIAL USE ONLY

Vaccine	Date vaccine administered	Vaccinator	Site	Vaccine Lot #	Exp	Mfr	Date of VIS	VIS given	Patient Signature
High Dose	-22					AVP	8/6/2021	-22	

Cosignature _____