



The Township of Ewing Board of Health

BERT H. STEINMANN, MAYOR

JAMES P. McMANIMON, BUSINESS ADMINISTRATOR

CHILD INFLUENZA REGISTRATION FORM 2020-2021

(6 months to 17 years old)

Write with ink only

Child's full name:	Birth Date	Child's Age	
Parent name print:		Male	Female
Child's Address	City:	State:	Zip:
Phone Number:	Cell:		
What School does your child attend?			

Primary Insurance card holder

Card holder's Name (print):		Card holder's birth date:	
Card holder's address (if different than child's):			
Apt:	City:	State:	Zip:
Relationship to child			
Insurance Name		ID number	Group #

Please circle answer

Does your child have any allergies to Latex /Medication	Y	N	Does your child have asthma?	Y	N
What medication?			Is your child sick now-Cough, sneezing, head cold, fever?	Y	N
Is your child allergic to eggs or egg products?	Y	N	Has the child been sick in the past week?	Y	N
Any allergies to Thimerosal or Neomycin?	Y	N	Any history of Guillain-Barre Syndrome	Y	N
Has your child ever reacted to a previous flu vaccine?	Y	N	Does your child take steroids (oral or IV)?	Y	N
Is your child immunosuppressed (low white blood cells)?	Y	N	Is he/she on chemotherapy?	Y	N
Has your child had any vaccines in the past 4 weeks?	Y	N	Is your child pregnant? Breast feeding? (teens)	Y	N

Permission for Influenza vaccination, examination, tests, and entry on the NJIIS Computer Registry

I understand the benefits and risks of the Influenza vaccine & I request and consent that it be given to me or the person named above of whom I am the parent, guardian, or authorized person. My signature indicates that I understand that my information will be kept confidential however, if applicable, I give permission to bill Medicare/Insurance for eligible benefits. I understand that there will be no charge if Insurance does not pay.

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history. I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3. I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health and Senior Services (NJDHSS). The NJDHSS may be contacted at the website or telephone number listed above.

There is no cost to participate in this program. By signing this I agree to participate in the NJIIS program.

My child's health insurance is: **No Health Insurance** **New Jersey Family Care Plan A** **Private Insurance**

Parent- Guardian's Name (print) _____ Relationship to child _____

Vaccine	Date vaccine administered	Vaccinator	Site	Vaccine Lot #	Mfr	Date VIS was issued	Date Flu VIS given	Parent signature
						8/15/2019		

Temperature Reading _____ Oral- Axillary (Hold Flu vaccination if ≥ 100 Oral, Hold Flu vaccination If ≥ 99 axillary)