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Health Officer

# The Township of Ewing Board of Health

BERT H. STEINMANN, MAYOR JAMES P. McMANIMON, BUSINESS ADMINISTRATOR

## CHILD INFLUENZA REGISTRATION FORM

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

### *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 riles 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 |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

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