Influenza Registration Form 2024-2025 Child (6 months -17 yrs)

Ewing Township Health Department

2 Jake Garzio Drive Ewing NJ 08628

609-883-2900 Ext 7619   Mayor Bert Steinmann

Child's Full Name:		
Child's Address:		
City:	State: Zip:	Phone:
Male Female	Child's birthdate:	Child's Age:

PRIMARY Insurance Information		
Is your child currently Insured?	Yes	No
Is the parent currently employed?	Yes	No
PRIMARY Card Holder's Name:		
PRIMARY Card Holder's Address (If different than the child's):		
Primary Card Holder's Date of birth:		
Type of insurance: (check)		
Medicaid New Jersey Family Care Plan	AETNA	Cigna
No Health Insurance	Ameri Health	United
Other:	NJ DIrect	Horizon Blue Cross and Blue Shield
ID Number & letters:		
Group number:		

SECONDARY Insurance Information		
Are you currently Insured?	Yes	No
Is the SECONDARY card holder employed?	Yes	No
SECONDARY insurance Card Holder's Name:		
SECONDARY Card Holder's Address (If different than the child's):		
Secondary Card Holder's Card Holder's Date of birth:		
Type of insurance: (circle)		
Medicaid New Jersey Family Care Plan	AETNA	Cigna
No Health Insurance	Ameri Health	United
Other:	NJ DIrect	Horizon Blue Cross and Blue Shield
ID Number & letters:		
Group number:		

QUESTIONS *(Please check the answer)*	Yes	No
Does your child have an allergy to any medications? What?		
Is your child allergic to **Latex**?		
Is your child allergic to **eggs** or egg products?		
Has your child ever had a rash, hives, difficulty breathing, or high fever to the flu vaccine?		
Is your child currently ill with a cough, fever, sneezing, or a head cold?		
Does your child have a chronic illness? Diabetes, Cancer		
Does your child have Asthma, or pulmonary disease?		
Are you pregnant or breastfeeding(Teens)?		
Is your child immunosuppressed (low WBC's)?		
Is your child taking steroids (oral or IV)?		
Is your child receiving any Chemotherapy?		
Is your child allergic to Thimerosal (preservative) or Neomycin?		
Has your child ever had **Guillain-Barre** Syndrome?		

INFLUENZA CONSENT

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 childcare 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 healthcare 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 this program.

Oral- Axillary Temperature Reading _____________ (Hold Flu vaccination if $\geq$ **100 Orally**, or $\geq$ **99 axillary)**

Parent name Print **Relationship**

Parent Signature **Date**

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

Official Use Only

Vaccine: Fluzone Flulaval Regular Dose	Date vaccine given:	Site: Left arm-thigh Right arm-thigh
	Vaccinator signature:	

revised 8/24/2024