Adult Influenza Registration Form 2024-2025

Ewing Township Health Department

2 Jake Garzio Drive Ewing NJ 08628

609-883-2900 Ext 7619 Mayor Bert Steinmann

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

PRIMARY Insurance Information		
Are you currently Insured?	Yes ☐ No ☐	
PRIMARY Card Holder's Name:		
Primary Card Holder's Date of birth:		
Type of insurance: (check)		
☐ Medicare	☐ AETNA	☐ Cigna
☐ AARP	☐ 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 Card Holder's *Date of birth* :		
Type of insurance: (circle)		
☐ Medicare	☐ AETNA	☐ Cigna
☐ AARP	☐ Ameri Health	☐ United
☐ Other:	☐ NJ DIrect	☐ Horizon Blue Cross and Blue Shield
ID Number & letters:		
Group number:		

QUESTIONS Please check the answer	Yes	No
Do you have an allergy to any medications? What?	☐	☐
Are you allergic to **Latex**?	☐	☐
Are you allergic to **eggs** or egg products?	☐	☐
Have you ever had a rash, hives, difficulty breathing, or high fever 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**

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

Official Use Only

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