Ewing Township
2 Jake Garzio Drive Ewing NJ 08628 609-883-2900 ext 7619
Kristin Reed Health Officer
Adult Influenza Registration Form 2019-2020

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	Are you pregnant or breast feeding? ☐ Y ☐ N
List medication?	Do you have Asthma, or pulmonary disease? ☐ Y ☐ N
Are you allergic 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 the flu vaccine? ☐ Y ☐ N	Are you on Chemotherapy? ☐ Y ☐ N
Are you currently Ill? ☐ Y ☐ N Do you have a cough, fever, sneezing, head cold?	Are you allergic to Thimerosal (preservative) ☐ Y ☐ N or Neomycin?
Do you have a chronic illness? ☐ Y ☐ N	Have you ever had **Guillain-Barre** Syndrome? ☐ Y ☐ N
High BP High Cholesterol, Diabetes, Cancer, COPD	Other:

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 doesn't pay. Signature_____

Vaccine	Date vaccine a	Vaccinator	Site	Vaccine Lot #	Exp	Mfr	Date of VIS	VIS given	Patient Signature
High Dose	/ /19					AVP	8/15/2019	/ /19	

Cosignature _____