Borough of Lincoln Park

34 Chapel Hill Road • Lincoln Park, NJ 07035 - 1998

Health Department TELE: (973) 694-6306 FAX: (973) 628-9512

HIGH DOSE (MUST BE 65 OR OLDER)

INFLUENZA VACCINE

Name _____ **DOB** _____ **Sex** _____

Address _____ **City/State** _____

Phone # _____ **Medicare #** ***(must have part "B")*** _____ ***Paid*** ____

Please answer the following questions (circle):

1) Are you allergic to eggs or egg products?	**Yes**	**No**
2) Are you allergic to Thimerosal? (a preservative)	**Yes**	**No**
3) Are you allergic to Epinephrine?	**Yes**	**No**
4) Are you allergic to Latex?	**Yes**	**No**
5) Do you have a fever or any active infection today?	**Yes**	**No**
6) Are you receiving chemotherapy or any type of immunosuppressants?	**Yes**	**No**
7) Do you take blood thinners?	**Yes**	**No**
8) Do you have Multiple Sclerosis?	**Yes**	**No**
9) Have you ever had Guillain-Barre Syndrome?	**Yes**	**No**
10) Have you had a reaction to the flu vaccine in the past?	**Yes**	**No**

Please explain any yes answers _____

_____

Informed Consent

I have read the accompanying information from the CDC *"Inactivated Influenza Vaccine"* about influenza and the influenza vaccine. I have had the opportunity to ask questions about influenza and the vaccine which were answered to my satisfaction. I have answered truthfully those questions asked of me. I understand the benefits and risks of the influenza vaccine. I am at least 18 years of age. If I am not 18 years of age, my legal guardian is responsible for my consent. I am responsible for payment to the Borough Of Lincoln Park if not covered by Medicare Part "B". I request payment of authorized Medicare benefits, if I am eligible, be made on my behalf to the Borough Of Lincoln Park for the influenza vaccine. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits. I request that the vaccination be given to me or the person named above for whom I am authorized to give consent. I release the sponsoring organization and all personnel from any responsibility for my own health care needs or liability from health consequences, which may occur from participation in this program. I understand that, as a result of receiving this vaccination, there is no guarantee that I, or the person for whom this consent is given, will receive immunity or that I, or the person for whom this consent is given, will not experience adverse effects from the vaccine.

Signature _____ **Date** _____

To be completed by vaccinator

Vaccine Manufacturer _____ **Lot #** _____ **Exp. Date** _____

Administered by _____ **Site** _____