Salem County Department of Health & Human Services

SEASONAL INFLUENZA VACCINE (2014 - 2015)

Funded by the Salem County Board of Chosen Freeholders

For more information, call: 856-935-7510, Ext. 8477 or 358-3857, Ext. 8477

The Salem County Department of Health will keep this medical record on file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given.

"I have read or have had explained to me the information sheet provided to me about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request.

***Privacy Policy* – I have seen and been informed of the Privacy Practices of the Salem County Health & Human Services Department, and I authorize the use and disclosure of my Medical Information concerning the Influenza Immunization as per these practices. I have seen or been offered a Vaccine Information Statement (VIS)**

I give my permission for my immunization information to be included in the ***NJ Immunization Information System.*** Information about this program is available upon request. "

I release the Salem County Department of Health & Human Services, and the officers, directors, agents, contractors and employees of this organization from any liability whatsoever arising out of the immunization.

Please fill out the following section between the bars :

Are you currently taking medication to thin your blood? Aspirin, Coumadin, Heparin, etc. **Yes** ☐ **No** ☐

Are you allergic to eggs? **Yes** ☐ **No** ☐

Do you have a latex allergy? **Yes** ☐ **No** ☐

Have you had a serious allergic reaction to a previous dose of influenza vaccine? **Yes** ☐ **No** ☐

Do you have a history of Guillain-Barre Syndrome? (neuro-muscular disorder) **Yes** ☐ **No** ☐

Do you have a fever or are you presently ill? **Yes** ☐ **No** ☐

Females only: Are you pregnant or think you may be pregnant? **Yes** ☐ **No** ☐

Township/Boro _____ Race _____ Sex: M ☐ F ☐

Last Name _____ First _____ MI ____

Phone _____ Birth date _____ Age _____ County _____

Address _____

City _____ State _____ ZIP _____

PRINT

X _____ *(to be signed at time of vaccination)*

Signature / Person to receive vaccine or person authorized to make the request (parent or guardian).

FOR OFFICE USE ONLY: SALEM COUNTY DEPARTMENT OF HEALTH & HUMAN SERVICES

Site of injection: ____ Left Deltoid _____ Right Deltoid _____ Other _____

Date/Place Vaccine administered:

Exp. Date: expires Lot #

Signature/Title of Vaccine Administrator

_____

Label