Salem County Department of Health & Human Services (SCDHHS)
SEASONAL INFLUENZA VACCINE 2024-2025
Funded by the Salem County Board of County Commissioners **NJIIS#:_____**
110 5th Street, Salem, NJ 08079
856-935-7510 ext. 8474 **VIS Date: _____**

PARTICIPANT INFORMATION (Please print)

LAST NAME	FIRST NAME	M.I.

DATE OF BIRTH	AGE	GENDER	RACE	ETHNICITY

ADDRESS	CITY	STATE	ZIP	COUNTY

SOCIAL SECURITY NUMBER (SSN)	TELEPHONE NUMBER

INSURANCE INFORMATION (Please print)

Primary Insurance Name:
Insurance ID Number:
☐ **No Insurance**

VACCINE SCREENING CHECKLIST

Before receiving an influenza vaccination, please answer the following questions:	Yes	No
Is the person to be vaccinated 3 years of age or older?		
Has the person to be vaccinated received a flu shot before?		
Has the person to be vaccinated ever had a serious reaction to a previous dose of the flu vaccine?		
Does the person to be vaccinated have a severe allergy to any ingredients in the flu vaccine?		
Is the person to be vaccinated sick today?		
Has the person to be vaccinated ever had Guillain-Barre Syndrome (a type of temporary muscle weakness)?		

*According to the CDC people with egg allergy may receive any flu vaccine that is otherwise appropriate for their age and health status. https://www.cdc.gov/flu/prevent/egg-allergies.htm

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TO BE COMPLETED BY SCDHHS STAFF

IM injection site:

☐ Left Deltoid ☐ Right Deltoid ☐ Other

_____
Signature & Title of Vaccine Administrator

Vaccine Label
Date/Place Vaccine Administered
Exp. Date and Lot #

Reviewed By: _____

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CONSENT (Please read before signing)

I understand that by signing this form, I am consenting for the named participant to receive the influenza vaccine. I have answered all questions on this form appropriately and to the best of my knowledge. I was provided and have reviewed the Vaccine Information Statement and was provided an opportunity to ask questions.

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 child care 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 rules 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 health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at www.njiis.nj.gov or by calling 609-826-4860. There is no cost to participate in this program.

☐ Yes, I would like to participate in this program.
☐ No, I do not want to participate in this program

Information about this program is available upon request. SCDHHS will keep this medical record on file for a minimum of 3 years.

I understand that SCDHHS, its employees, representatives, agents, and volunteers are free from any liability for giving me the influenza vaccination. I understand that follow-up medical attention may be necessary in the event of exposure and agree to follow SCDHHS' exposure follow-up protocols. I accept responsibility for seeking medical attention for any problems associated with my receiving the influenza vaccination.

I authorize the submission of a claim to Medicare, Medicaid or any other payer for the services provided to me by SCDHHS now, in the past or in the future, until I revoke this authorization in writing by certified mail. I understand that an insurance claim will not be submitted if I elected to opt out of insurance billing. I agree to immediately remit to SCDHHS any payment that I receive directly from insurance or any source for the services provided to me and I assign all rights to such payments to SCDHHS. I authorize SCDHHS to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical insurance, billing or other relevant information about me to release such information to SCDHHS and its billing agents, the Centers for Medicare and Medicaid Services and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by SCDHHS, now, in the past or in the future. I also authorize SCDHHS to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information. I/We request payment of any medical insurance benefits to go directly to SCDHHS. I/We permit a copy of this authorization to be used in place of the original. A copy of this form is as valid as the original.

_____ Date: _____/_____/_____
Participant or Parent/Guardian Signature (month) (day) (year)

_____ _____
Parent or Guardian Name (please print) Relationship to vaccine recipient (please print)