

Salem County Department of Health & Human Services (SCDHHS)

NJIS #: _____

SEASONAL INFLUENZA VACCINE 2022-2023

Funded by the Salem County Board of County Commissioners

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: |
| <input type="checkbox"/> 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 eggs? | | |
| 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)? | | |

TO BE COMPLETED BY SCDHHS STAFF

Clinic: Salem County Health Department

IM injection site:

Left Deltoid Right Deltoid Other

| |
|--------------|
| Reviewed By: |
| |

| |
|--|
| Label Date/Place Vaccine administered Exp. Date and Lot # |
|--|

Signature & Title of Vaccine Administrator

Salem County Department of Health & Human Services (SCDHHS)

SEASONAL INFLUENZA VACCINE 2022-2023

Funded by the Salem County Board of County Commissioners

110 5th Street, Salem, NJ 08079

856-935-7510 ext. 8474

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 give my permission for my immunization information to be included in the *New Jersey Immunization Information System*. 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.

Participant or Parent/Guardian Signature

Date: ____/____/____
(month) (day) (year)

Parent or Guardian Name (please print)

Relationship to vaccine recipient (please print)