Date: _____

Report #:

Location: Middletown DOH

~~Kings Highway~~

Middletown NJ 07748

MONMOUTH COUNTY HEALTH DEPARTMENT (MCHD)

50 East Main St

Freehold, NJ 07728, TEL: 732-431-7456

NJIIS# _____

EUA Date: _____

EUA Date Given: _____

■ Health Dept.

☐

Section 1: (PLEASE PRINT)

LAST NAME	(FIRST)	(M.I.)	DATE OF BIRTH / / (month) (day) (year)
MAILING ADDRESS	CITY	STATE	ZIP GENDER (circle one) M or F or N
PHONE:	EMAIL: optional		

Section 2: Insurance NOT MANDATORY

PRIMARY INSURANCE: _____ INSURANCE ID: _____	**VFA ELIGIBLE** I verify that I have NO MEDICAL INSURANCE or NO VACCINE COVERAGE **[Initial here]** _____
☐ No Insurance	

Section 3: Consent for Vaccination

I have received the Vaccine Information Statement (VIS) for the vaccine/s that will be administered today. I understand the risks and benefits. Vaccines provided through this federal and state program will be recorded in NJIIS (New Jersey Immunization Information System). A copy of this form is as valid as the original.

I give consent to the *Monmouth County Health Department* to administer requested/required vaccine to me or the person named above for whom I am authorized to give consent.

Signature _____ **Date:** _____

(Print) _____ Relationship: _____

FOR *ADMINISTRATIVE* USE ONLY

Vaccine	Date 1st Dose Administered	Date 2nd Dose Administered	Route/Site		Staff Signature	Vaccine Manufacturer	Lot Number/ Exp Date
			1st Dose	2nd Dose			
			IM R ☐ L ☐ Arm ☐ Leg ☐	IM ☐ R ☐ L ☐ Arm ☐ Leg			

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

For *ADULT* patients to be vaccinated: The following questions will help us determine if there is any reason we should not give you inactivated injectable influenza today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

		Yes	No	Don't Know
1.	Is the person to be vaccinated sick today?	☐	☐	☐
2.	Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	☐	☐	☐
3.	Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4.	Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐

Form Completed by: _____ Date: ___/___/___
(month) (day) (year)

Form Reviewed by: _____ Date: ___/___/___
(month) (day) (year)

FOR *ADMINISTRATIVE* USE ONLY

Vaccine	Date 1st Dose Administered	Date 2nd Dose Administered	Route/Site		Staff Signature	Vaccine Manufacturer	Lot Number/ Exp Date
			1st Dose	2nd Dose			
Injectable Influenza			IM ☐R ☐L ☐Arm ☐Leg	IM ☐R ☐L ☐Arm ☐Leg			
Injectable Influenza			IM ☐R ☐L ☐Arm ☐Leg	IM ☐R ☐L ☐Arm ☐Leg			

Vaccine	Description	