2021 Inactivated Injectable Influenza Vaccination Program

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we *should* not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It only means additional questions must be asked by the nurse. If a question is not clear, please ask for an explanation.

	No	Yes	Don't Know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy 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: _____

Form reviewed by: _____ Date: _____

www.immunize.org/catg.d/p4066.pdf • Item#P4066 (9/2020)

INFLUENZA VACCINE ADMINISTRATION RECORD

Consent: I have read or have had explained to me the information about the **Influenza vaccine,** including a copy of the current Vaccine Information Statement (VIS 8/15/19) which has been made available online and at the clinic location. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the influenza vaccine be given to me or to the person named below for whom I am authorized to make this request. I understand that the receipt of this vaccine may be recorded in the NJ Immunization Information System (NJIIS) registry.

Information About Person to Receive Vaccine:				**For Clinic Use:**
	☐ Male ☐ Female			☐ Madison Health Dept. ☐ Other:
Name (First MI Last)	***Gender***	***Date of Birth***	***Age***	***Clinic Location*** ☐LA ☐NA ☐LT ☐RA ☐RT
Address				***Vaccine Date*** ***Vaccine Location***
City	***State***	***Zip***		***Vaccine Manufacturer***
	☐Home ☐Cell ☐Work			
Phone	***Phone Type***			**Lot Number**
Signature of person to receive vaccine or one authorized to make request (parent/guardian)			***Date***	**Vaccinator**
Medicare Number (If applicable)				

VFC ☐No Insurance ☐NJ Family Care Plan A

☐**PRIVATE**

VFA ☐No insurance ☐Vax not covered by insurance ☐317