



2020 - 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the person to be vaccinated have an allergy to a component of the vaccine? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has the person to be vaccinated ever had Guillain-Barré syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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:	
<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Madison Health Dept. <input type="checkbox"/> Other:	
Name (First MI Last)	Gender	Date of Birth	Age	Clinic Location	
				<input type="checkbox"/> LA <input type="checkbox"/> NA <input type="checkbox"/> LT <input type="checkbox"/> RA <input type="checkbox"/> RT	
Address				Vaccine Date	Vaccine Location
City	State	Zip		Vaccine Manufacturer	
				<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> 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
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