PALISADES PARK HEALTH DEPARTMENT

275 Broad Avenue, Palisade Park, New Jersey 07650, 201-585-4105

2020-2021 INACTIVATED INJECTABLE INFLUENZA VACCINE CONSENT

NAME:____**BIRTH DATE:**____________________

ADDRESS:____

CITY:____________________________________ **STATE:**__________ **ZIP:**____________

PHONE:____________________________________**MALE:** __________ **FEMALE:** _________

Immunization Screening	**YES**	**NO**
Is the person to be vaccinated sick today? **Temperature:** ______		
Is the person to be vaccinated ill with COVID-19 or COVID-19 symptoms?		
Is the person to be vaccinated allergic to any component of the vaccine?		
Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?		
Has the person to be vaccinated ever had Guillain-Barré syndrome?		
Is the person to be vaccinated pregnant or could she become pregnant within next month?		

I have received (VIS 8/15/19) Influenza Vaccine Inactivated or Recombinant) the information about influenza, the vaccine, and special precautions. I had an opportunity to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine. I hereby grant, authorize, and permit the Palisade Park Health Department to inoculate me with influenza virus vaccine, I do hereby release and forever discharge the Palisade Park Health Department and the physician, and/or its' employees and volunteers, and the Health Awareness Regional Program (HARP) of Health Hackensack University Medical Center Hackensack Meridian from any and all liability in connection with this inoculation, suits, damages, claims or demands, if any, arising from said inoculation. I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Palisade Park Health Department for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I acknowledge receiving the Notice of Health Information Practices.

X____ **X**________________

SIGNATURE **DATE**

Vaccine Manufacturer and Lot Number:	Site of Injection: □ Left Arm □ Right Arm	Dose for children under 3 years.
Vaccine Administrator:		Follow-up instruction if needed.
Reference: www.immunize.org 9/20		