Date: ___/___/___

Report #: _____

CUMBERLAND COUNTY HEALTH DEPARTMENT (CCHD) NJIIS# _____
309 Buck Street
MILLVILLE, NJ 08332, TEL: 856-327-7602

Site Name and Address:

_____
_____

Adult

VIS Date: 8/7/2015

VIS Date Given: _____

☐ HEALTH DEPT

☐ HIGH DOSE

☐ VFC

Section 1: (PLEASE PRINT)

LAST NAME	(FIRST)	(M.I.)	BIRTH DATE & AGE: ___/___/___ (month) (day) (year)
MAILING ADDRESS CITY STATE ZIP MUNICIPALITY			GENDER (circle one) F or M
SSN (optional) ☐☐☐☐☐☐☐☐☐	PHONE		

Section 2: Insurance

PRIMARY INSURANCE: _____	SECONDARY INSURANCE: _____
INSURANCE ID: _____	INSURANCE ID: _____

☐ No Insurance

Section 3: Consent for Vaccination

I authorize the submission of a claim to Medicare, Medicaid or any other payer for the services provided to me by CCHD 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 CCHD 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 CCHD. I authorize CCHD 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 CCHD 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 CCHD, now, in the past or in the future. I also authorize CCHD 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 CCHD. 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. I have received the Vaccine Information Statement for the current influenza season and understand the risks and benefits. Immunizations provided thru the NJ Department of Health VFC Program will be registered in NJIIS (NJ Immunization Information System). Fee schedule is available upon request.

I give consent to the *Cumberland County Health Department* to administer the influenza vaccine to me or the person named above for whom I am authorized to give consent, as his/her parent/legal guardian.

Signature _____ Date: ___/___/___ (month) (day) (year)

(Print) _____ Relationship: _____

Section 4: Screening for Vaccine Eligibility*

Please complete screening question on the back of this form.

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		Sanofi ---------- GSK Segirus	
Hi Dose			IM ☐R ☐L ☐Arm ☐Leg	IM ☐R ☐L ☐Arm ☐Leg		Sanofi	

Vaccine	Description	✓
90653	Fluad 0.5ml High Dose for ages 65 years and above Sequirus	
90686	Fluzone Quad 0.5 ml for ages 3 years and above Sanofi Pasteur	