

Date: ___/___/___

CUMBERLAND COUNTY DEPARTMENT OF HEALTH

NJIS# _____

Report #: _____

309 Buck Street
MILLVILLE, NJ 08332
TEL: 856-327-7602

HEALTH DEPT

Site Name and Address:

HIGH DOSE

Adult

VFC

VIS Date: 08/06/2021

Section 1: (PLEASE PRINT)

VIS Date Given: _____

TEMPERATURE: _____

LAST NAME		FIRST		M.I.	BIRTH DATE & AGE: ____/____/____ (month) (day) (year)	
MAILING ADDRESS			CITY	STATE	ZIP	GENDER F (circle one) M
MUNICIPALITY: <input type="checkbox"/> Bridgeton <input type="checkbox"/> Commercial Twp. <input type="checkbox"/> Deerfield Twp. <input type="checkbox"/> Vineland <input type="checkbox"/> Stow Creek Twp. <input type="checkbox"/> Fairfield Twp. <input type="checkbox"/> Greenwich Twp. <input type="checkbox"/> Hopewell Twp. <input type="checkbox"/> Downe Twp. <input type="checkbox"/> Upper Deerfield Twp. <input type="checkbox"/> Lawrence Twp. <input type="checkbox"/> Maurice River Twp. <input type="checkbox"/> Millville <input type="checkbox"/> Shiloh <input type="checkbox"/> Other _____						
SSN (optional) [][][][][][][][][]				PHONE		

Section 2: Insurance

Please check the box for your insurance coverage

MEDICARE <input type="checkbox"/> Medicare <input type="checkbox"/> Horizon <input type="checkbox"/> Aetna <input type="checkbox"/> Other		MEDICAID Policy #: _____ <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Plan D <input type="checkbox"/> Other	
PRIVATE INSURANCE Name: _____ Policy #: _____		<input type="checkbox"/> 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 CCDOH 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 CCDOH 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 CCDOH. I authorize CCDOH 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 CCDOH 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 CCDOH, now, in the past or in the future. I also authorize CCDOH 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 CCDOH. 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 through the NJ Department of Health VFC Program will be registered in NJIS (NJ Immunization System). Fee schedule is available upon request.

I give consent to the *Cumberland County Department of Health* 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 questions 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. Did you read the COVID-19 screening questions and speak to CCDOH staff if needed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. 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"/>
5. Has the person to be vaccinated ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 <input type="checkbox"/> R <input type="checkbox"/> L	IM <input type="checkbox"/> R <input type="checkbox"/> L		Sanofi GSK Seqirus	
			<input type="checkbox"/> Arm <input type="checkbox"/> Leg	<input type="checkbox"/> Arm <input type="checkbox"/> Leg			
Hi Dose			IM <input type="checkbox"/> R <input type="checkbox"/> L	IM <input type="checkbox"/> R <input type="checkbox"/> L		Sanofi	
			<input type="checkbox"/> Arm <input type="checkbox"/> Leg	<input type="checkbox"/> Arm <input type="checkbox"/> Leg			

<u>Vaccine</u>	<u>Description</u>
XXXXX	Flulaval Quadrivalent 0.5 mL, for ages 6 months and above
XXXXX	Fluad Quadrivalent High Dose 0.5 mL, for ages 65 years and above
XXXXX	VFC: Fluarix Quadrivalent 0.5 mL, for ages 6 months and above