Date: / /

Report #: _____

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

Child

Site Name and Address:

_____
_____

☐ **Health Dept.**

VIS Date: 8/7/2015

VIS Date Given: _____

☐ **VFC**

Section 1: (PLEASE PRINT)

LAST NAME	(FIRST)	(M.I.)	BIRTH DATE and 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 my child 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. I/We understand that the usual CCHD policy is that payment is due at the time of service. 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 Influenza Vaccination

For use with people age 2 through 18 years: The following questions will help us determine if there is any resason we should not give you or your child influenza vaccine. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vacccinated. It just means additional questions must be asked. If a question is not clear, please as 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.	Is the person to be vaccinated younger than age 2 years?	☐	☐	☐
5.	Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?	☐	☐	☐
6.	If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider told you the child had wheezing or asthma?	☐	☐	☐
7.	Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem; or in the past 3 months, have they taken medication that weakens the immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; or have they had radiation treatments?	☐	☐	☐
8.	Is the person to be vaccinated receiving antiviral medications?			
9.	Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?			
10.	Is the person to be vaccinated pregnant or could she become pregnant within the next month?	☐	☐	☐
11.	Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐
12.	Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	☐	☐	☐
13.	Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	☐	☐	☐

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	

Vaccine	Description	✓
90685	Fluzone Quad 0.25 ml for ages 6-35 months Sanofi Pasteur	
90686	Fluzone Quad 0.5 ml for ages 3 years and above Sanofi Pasteur	