Date: / /

Report #: _____

Site Name and Address:

_____

_____

CUMBERLAND COUNTY DEPARTMENT OF HEALTH
309 Buck Street
MILLVILLE, NJ 08332
TEL: 856-327-7602

NJIIS# _____

☐ Health Dept.

☐ VFC

Child

VIS Date: 08/06/2021

VIS Date Given: _____

TEMPERATURE: _____

Section 1: (PLEASE PRINT)

LAST NAME	FIRST	M.I.	BIRTH DATE and AGE: / / (month) (day) (year)
MAILING ADDRESS CITY STATE ZIP			GENDER (circle one) F or M

MUNICIPALITY

☐ Bridgeton ☐ Commercial Twp. ☐ Deerfield Twp. ☐ Vineland ☐ Stow Creek Twp.
☐ Fairfield Twp. ☐ Greenwich Twp. ☐ Hopewell Twp. ☐ Downe Twp. ☐ Upper Deerfied Twp.
☐ Lawrence Twp. ☐ Maurice River Twp. ☐ Millville ☐ Shiloh ☐ Other _____

SSN (optional) ☐☐☐☐☐☐☐☐☐

PHONE

Section 2: Insurance

MEDICAID Policy #: _____

☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Other

PRIVATE INSURANCE Name: _____

Policy #: _____

☐ 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 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. I/We understand that the usual CCDOH 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 through 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 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 Influenza Vaccination

For use with people age 2 through 18 years: **The following questions will help us determine if there is any reason 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 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 a CCDOH staff if necessary?	☐	☐	☐
2. Is the person to be vaccinated sick today?	☐	☐	☐
3. Does the person to be vaccinated have an allergy to eggs or a component of the vaccine?	☐	☐	☐
4. Has the person to be vaccinated ever had a serious reaction to the flu vaccine in the past?	☐	☐	☐
5. Is the person to be vaccinated younger than 2 years of age?	☐	☐	☐
6. Does the person to be vaccinated have a long-term health issue like heart disease, lung disease, asthma, kidney disease, neurological or neuromuscular disease, liver disease, metabolic disease (diabetes), or a blood disorder?	☐	☐	☐
7. If the person to be vaccinated is aged 2 through 4 years, has a healthcare provider told you the child had asthma or wheezing in the past 12 months?	☐	☐	☐
8. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem, or in the past 3 months taken medication to weaken the immune system (cortisone, prednisone, steroids, anticancer drugs; or have they had radiation?	☐	☐	☐
9. Is the person to be vaccinated receiving antiviral medications?	☐	☐	☐
10. Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	☐	☐	☐
11. Is the person to be vaccinated pregnant or could become pregnant within the next month?	☐	☐	☐
12. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐
13. Does the person to be vaccinated live with or have close contact with someone who has a compromised immune system and who must be in protective isolation (e.g. an isolation room of a bone marrow transplant unit)?	☐	☐	☐
14. Has the person to be vaccinated received 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 / Seqirus	

Vaccine	Description	
XXXXX	Flulaval Quadrivalent 0.5 mL, for ages 6 months and above	
XXXXX	VFC: Fluarix Quadrivalent 0.5 mL, for ages 6 months and above	