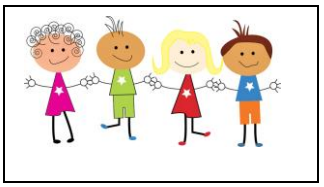
Ewing Township Health Department
2 Jake Garzio Drive Ewing NJ 08628 609-883-2900 ext 7619
Child Influenza Vaccination (6 months to 17 years old)



Child's full name:		
Child's Address:		Apt:
City:	State: Zip:	Phone
Child's age:	Child's Birth date:	
Male ☐ Female ☐	What school does your child attend?	

PRIMARY Insurance Information

Is your child currently **Insured**? Yes ☐ No ☐

Is the parent currently employed? Yes ☐ No ☐

PRIMARY Card Holder's Name:

PRIMARY Card Holder's Address (If different than the child's):

Primary Card Holders Date of birth:

Type of insurance: **(circle)**

AETNA ☐ Ameri Health ☐ Cigna ☐ United ☐ NJ Direct ☐ No health insurance ☐

Horizon Blue Cross Blue Shield (BCBS) ☐ Medicaid New Jersey Family Care Plan_____ ☐ Other:

ID Number & letters:

Group number:

SECONDARY Insurance Information

Do you have **SECONDARY** Insurance? Yes ☐ No ☐

Is the **SECONDARY** card holder employed? Yes ☐ No ☐

Secondary Insurance Card Holder's Name:

Secondary Card Holder's Date of Birth:

Type of insurance: **(circle)**

AETNA ☐ Ameri Health ☐ Cigna ☐ United ☐ NJ Direct ☐ No health insurance ☐

Horizon Blue Cross Blue Shield (BCBS) ☐ Medicaid New Jersey Family Care Plan____☐____ Other:

ID Number & letters:

Group number:

Please check the answer	Yes	No
Is your child have an allergy to any medications? List medication?	☐	☐
Is your child allergic to **Latex,** to **eggs,** or egg products?	☐	☐
Has your child had any vaccines in the past 4 weeks?	☐	☐
Has your child had a reaction to the flu vaccine?	☐	☐
Is your child currently ill with a cough, fever, sneezing, a head cold today or in the past week?	☐	☐
Does your child have a chronic illness?	☐	☐
Does your child have Asthma, or pulmonary disease?	☐	☐
Is your child pregnant or breastfeeding(teens)?	☐	☐
Is your child immunosuppressed (low WBC's)?	☐	☐
Is your child taking steroids (oral or IV)?	☐	☐
Is your child on Chemotherapy?	☐	☐
Is your child allergic to Thimerosal (preservative) or Neomycin?	☐	☐
Has your child ever had or been diagnosed with **Guillain-Barre** Syndrome?	☐	☐

INFLUENZA CONSENT

Permission for *Influenza* vaccination, examination, tests, and entry on the NJIIS Computer Registry

I understand the benefits and risks of the Influenza vaccine & I request and consent that it be given to me or the person named above of whom I am the parent, guardian, or authorized person. My signature indicates that I understand that my information will be kept confidential however, if applicable, I give permission to bill Medicare/Insurance for eligible benefits. **I understand that there will be no charge** if Insurance does not pay. I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history. I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed childcare centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and riles at N.J.A.C. 8:57-3. I understand that I can get a copy of my/my child's record from my primary healthcare provider, my local health department, or the New Jersey Department of Health and Senior Services (NJDHSS). The NJDHSS may be contacted at the website or telephone number listed above. There is no cost to participate in this program. By signing this I agree to participate in this program.

Parent-Guardian's Name_____**Relationship** _____

Parent -Guardian's Signature_____

Temperature Reading _____ Oral- Axillary (Hold Flu vaccination if **≥ 100** Oral, Hold Flu vaccination If **≥ 99** axillary)

VIS: Date Published 8/6/2021	Date VIS given:	Initial for VIS receipt:

Official Use Only

VIS: Date Published 8/6/2021	Site Left arm Right arm	
Vaccine: Fluarix Fluzone		
Vaccinator signature:		