Long Beach Island Health Department

I have read, or had explained to me, the information regarding influenza and influenza vaccine. I have had a chance to ask questions and receive answers to my satisfaction. I believe that I understand the benefits and risks of influenza vaccine and ask that the vaccine to be given to me, or to the person below for whom I am authorized to make this request. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its Agents. I request the payment of authorized Medicare benefits be made on my behalf to Long Beach Island Health Department for services rendered to me. I understand I am responsible for payment of services if my Medicare card is declined. I acknowledge I have viewed a copy of the Long Beach Island Health Department's Notice of Privacy Practices.

First Name **Middle Initial** **Last Name**

Address **City, State, ZIP** **Age**

Date of Birth **Phone Number**

Medicare Number

Patient Signature: X_____ **Date:**_____

LONG BEACH ISLAND HEALTH DEPARTMENT

FOR CLINIC/OFFICE USE ONLY

Clinic/Office Address St. Francis HD O.V. H.V.

High Dose Regular Seasonal

Screening Questions:

Is the patient sick today? Y N

Does the patient have any allergies? Y N

Has the patient had a flu shot in the past? Y N

Site of Injection (circle) L R

Date Vaccine Administered_____

Vaccine Mfr./Lot#

Signature of Vaccine Administrator X_____

Influenza 08/15/2019 Vaccine Information Statement