LONG BEACH ISLAND HEALTH DEPARTMENT
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Public Health
Prevent. Promote. Protect.

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# Flu Consent Form

| First Name: | Middle Initial: | Last Name: |
|---|---|---|
| Address: | City, State, ZIP | |
| Age: | Date of Birth: | |
| Phone Number: | Medicare Number: | |

| **Screening Questions** | **Yes** | **No** |
|---|---|---|
| Are you sick today? | ☐ | ☐ |
| Have you had a flu shot in the past? | ☐ | ☐ |
| Do you have any allergies to medication/food/vaccine component/latex? | ☐ | ☐ |

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.

**Signature X:** _____ **Date:**_____

# CLINIC USE ONLY

Clinic/Office Address: St. Francis HV O.V.

Date Vaccine Administered: _____

Vaccine Mfr./ Lot #

High Dose Regular

Site of Injection (circle) L R

Signature of Vaccine Administrant X: _____

Influenza 08/06/2021 Vaccine Information Statement