



LONG BEACH ISLAND HEALTH DEPARTMENT  
2119 Long Beach Boulevard, 1<sup>st</sup> Floor  
Ship Bottom, NJ 08008  
www.lbihealth.com



**Public Health**  
Prevent. Promote. Protect.

Daniel J. Krupinski, MPH, HO, REHS  
Health Officer

Phone: 609-492-1212  
Fax: 609-492-9215

### **Flu Consent Form**

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

### **Screening Questions**

	<b>Yes</b>	<b>No</b>
Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a flu shot in the past?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any allergies to medication/food/vaccine component/latex?	<input type="checkbox"/>	<input type="checkbox"/>

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
--