WEST WINDSOR TOWNSHIP HEALTH DEPARTMENT

INFLUENZA VACCINATION APPLICATION

Please PRINT Clearly:

Last Name:_____ First Name:_____ MI:_____

Address:_____

City:_____ State: _____ Zip code:_____

Phone:_____ Gender:_____ Date of Birth:_____

Medicare Part B Members Only:

MEDICARE #:_____ **Part B Effective Date:**_____

(INCLUDE THE LETTER AFTER THE MEDICARE NUMBER. EXAMPLE: "555555555-**A**")

OR

Insurance Information

Primary Insurance Co:_____ ID#:_____ Grp#:_____

Policyholder Name:_____ ID#:_____

Policyholder DOB:_____ Policyholder Address:_____

Please answer the following:

Are you allergic to eggs or any vaccine ingredient: Yes _____No_____

Do you have a history of Guillain-Barre Syndrome? Yes _____No_____

Are you currently ill or pregnant? Yes_____No_____

Have you previously had a reaction to the influenza vaccine? Yes _____No_____

Influenza Vaccine Consent/ Patient Authorization

I have received the Vaccine Information Statement on the Influenza Vaccine? Yes____No_____

I understand the benefits and risks of the influenza vaccine and I request and consent that it be given to the person named above of who I am the guardian or authorized person. I release and waive any and all claims against West Windsor Township, its employees or its agents arising out of or related to administration of the influenza vaccine.
I authorize the release of any medical information provided on this form to process any claim. I authorize payment of medical benefits to West Windsor Township for services rendered.

*Signature:*_____ *Date:* _____

For Official Use Only

Site Given: _____ LA _____ RA Lot # _____

Nurses Signature: _____ Date: _____

Clinic:_____ ID Verification: _____ Initials: _____