INFLUENZA (FLU) VACCINE REGISTRATION AND CONSENT FORM

Township of Hamilton Division of Health

Please print clearly

NAME (last, first)			
STREET	EMAIL		
CITY	STATE	ZIP	
PHONE	DATE OF BIRTH	AGE	
MEDICARE Part B #	INSURANCE NAME & ID# GROUP #		

Please Answer The Following Questions:	**Yes**	**No**	HTHD
1. Is the person to be vaccinated sick today?			
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?			
3. Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past?			
4. Has the person to be vaccinated ever had Guillain-Barre syndrome, or any other neurological or neuromuscular disorder?			

- **I (or the individual on whose behalf I am signing) have read or had explained to me by the Township of Hamilton Division of Health (HTHD) staff** the attached information about influenza and the influenza vaccine. I (or the individual on whose behalf I am signing) had an opportunity to ask questions about influenza and the vaccine which were answered to my satisfaction, and I am 18 years of age or older. I (or the individual on whose behalf I am signing) have been informed of the Notice of Privacy Practices.
- I (or the individual on whose behalf I am signing) am not allergic to Epinephrine (adrenalin) the drug used to counteract an allergic reaction to a flu shot. I (or the individual on whose behalf I am signing) am not allergic to latex. I (or the individual on whose behalf I am signing) do not currently have a fever or the symptoms of an acute infection.
- I (or the individual on whose behalf I am signing) understand that the recommended immunization is one injection/dose. I (or the individual on whose behalf I am signing) understand that receipt of the vaccine does not completely protect me against the flu or other illnesses that resemble the flu. I (or the individual on whose behalf I am signing) further understand that if I (or the individual on whose behalf I am signing) have a condition of (or am undergoing treatment which causes) immune-suppression (the reduction in my body's ability to fight infection and illness), the effectiveness of the vaccine in prevention of the flu may be diminished. I (or the individual on whose behalf I am signing) believe I understand the risks and benefits of the vaccine.
- **I (or the individual on whose behalf I am signing) understand that it is my responsibility to remain in the vaccination area for 15 minutes after I receive the vaccine, in case I (or the individual on whose behalf I am signing) experience a reaction.**
- I (or the individual on whose behalf I am signing) agree to receive the influenza vaccine, and I (or the individual on whose behalf I am signing) hereby release **the Township of Hamilton, Division of Health, and their employees, servants, representatives, officers, and agents (together, the "Indemnities")** from any liability for giving me (or the individual on whose behalf I am signing) the influenza vaccination. I (or the individual on whose behalf I am signing) agree to indemnify, defend, and hold the indemnities harmless from any claim made by any person, (including the individual on whose behalf I am signing). If Medicare Part B eligible, or other insurance is provided, I (or the individual on whose behalf I am signing) authorize HTHD to bill Medicare Part B or other insurance for the immunization and I (or the individual on whose behalf I am signing) authorize Medicare or other insurance benefits to be paid directly to HTHD.
- **My signature (or the individual's signature on whose behalf I am signing) on this form means that all of the information provided in the Registration and Consent Form are true to the best of my knowledge. I (or the individual on whose behalf I am signing) understand that this form and my signature below are binding on me and my heirs, successors, and personal and legal representatives as well as those of the person on whose behalf I am signing. If I am not the being vaccinated, I warrant that I have the authority to give this consent for the person to be vaccinated.**

Signature: ____ **Date**: ____________________________

Relationship to person to be vaccinated (circle one): SELF PARENT GUARDIAN MEDICAL POWER OF ATTORNEY

OFFICIAL USE ONLY

Vaccination Site: ☐ Right Deltoid ☐ Left Deltoid

Manufacturer:

Lot Number:

Expiration Date:

Clinic Location: ______________________________ **VIS Publication Date**: ________ **Date Given**: _________

Vaccine Administered By: _____________________________________ **Date**: _________________________