



BURLINGTON COUNTY BOARD OF CHOSEN FREEHOLDERS

**BURLINGTON COUNTY HEALTH DEPARTMENT
SEASONAL INFLUENZA VACCINATION CLINIC PROGRAM**



Public Health
Prevent. Promote. Protect.

APPLICATION FOR SEASONAL INFLUENZA VACCINATION AND CONSENT FOR VACCINATION

Person to be vaccinated: _____

I, _____ have read or had explained to me by **Burlington County Health Department (BCHD) staff** the attached information about seasonal influenza and the seasonal influenza vaccine. I have had an opportunity to ask questions about seasonal influenza and the vaccine which were answered to my satisfaction, and I am 18 years of age or older. I have been informed of the Notice of Privacy Practices.

To my knowledge I am not allergic to chicken eggs or chicken egg products, or Thimerosal (Merthiolate) and have never been advised by my physician or other healthcare provider to not receive this vaccine.

I am not allergic to Epinephrine (adrenalin) the drug used to counteract an allergic reaction to a flu shot.

I do not currently have a fever or the symptoms of an acute infection.

I have never been paralyzed with Guillain-Barre Syndrome.

I understand that the recommended immunization is one injection/dose. I understand that receipt of the seasonal influenza vaccine does not completely protect me against the flu or other illnesses that resemble the flu. I further understand that if I have a condition of (or am undergoing treatment which causes) immuno-suppression (the reduction in my body's ability to fight infection and illness), the effectiveness of the vaccine in preventing the flu may be diminished. I believe I understand the risks and benefits of the vaccine.

I understand that it is my responsibility to remain in the vaccination area for 10 minutes after I receive the vaccine, in case I experience a reaction.

I agree to receive the seasonal influenza vaccine and I hereby release **the Burlington County Board of Chosen Freeholders, County Health Department 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 seasonal influenza vaccination. I agree to indemnify, defend, and hold the Indemnitees harmless from any claim made by any person, (including the individual on whose behalf I am signing). If Medicare Part B eligible, I authorize **Burlington County** to bill Medicare Part B for the immunization and I authorize Medicare benefits to be paid directly to the Burlington County Health Department.

My signature on this form means that all of the information provided in this Application and Consent Form are true to the best of my knowledge. I 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 person being vaccinated, I warrant that I have the authority to give this consent for the person to be vaccinated.

Signature _____ Relationship to person being vaccinated _____

Date _____ Street Address _____ City, State, Zip _____

Phone No. _____ Birth Date _____ Medicare Number and Letter _____
(Please show BCHD staff your card)

FOR CLINIC USE ONLY:

Clinic Site _____ Date Vaccinated: _____ Right Deltoid Left Deltoid

Nurse's Signature: _____ Manufacturer, Lot Number & Exp.: _____