



Cape May County Free Flu Clinic Patient Consent Form

Free Drive-Through Flu Clinic
Sunday, Oct. 23 9-3pm
Kindle Ford Autoplaza

Other flu clinics:
www.cmchealth.net
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Must be at least 14 years old at drive-through clinic!

Name: _____ Age: _____ Sex: Male Female

Home Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ E-mail (optional): _____
(to receive information on local public health programs and services)

Ethnicity:

- Hispanic or Latino
 Not Hispanic or Latino

Race:

- White Native Hawaiian or Other Pacific Islander
 Black or African American American Indian or Alaskan Native
 Asian Other

Are you a healthcare worker or do you work in a long-term care facility? Yes No Do you live with or take care of someone who is at high risk for influenza complications? Yes No

Where did you hear about today's flu clinic (newspaper, radio, website, school, work, e-mail, fax, road sign)? Did you get a flu vaccine last year? **If YES, where did you get it** (drive-through, other county health clinic, doctor, pharmacy, work, hospital, etc)? Yes No

Please specify: _____ Please specify: _____

VACCINE SCREENING QUESTIONS:

	Yes	No	
Do you have a severe allergy to eggs or other vaccine component?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, you must receive the flu vaccine from your doctor
Have you been diagnosed with Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a severe allergy to latex or Thimerosal?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, you cannot receive the vaccine at the drive-through clinic
Are you pregnant or planning to become pregnant in next month?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a chronic medical condition affecting lungs (including asthma), heart (not hypertension), kidney, liver, blood, neurological, or metabolic (diabetes) or are you immunosuppressed?	<input type="checkbox"/>	<input type="checkbox"/>	
If the person being vaccinated is 2-4 years of age, in the past 12 months did a doctor tell you that he/she had wheezing or asthma?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, you need the injectable vaccine, not FluMist
Are you taking antiviral medications or are you a child/teen on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have close contact with someone who is severely immunocompromised and who must be in protective isolation?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you received other vaccines in past month?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, tell the nurse about it
Have you ever had a serious reaction to a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a fever today?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, wait until after you're feeling better to get vaccinated

I have read the Influenza Vaccine Information Statement (ver. 07/26/11) and have had a chance to ask questions on the side effects/adverse reactions to the flu vaccine. I believe I understand the benefits and risks of the influenza vaccine and I request and consent that it be given to me. I hereby release the County of Cape May, Kindle Ford, and the person administering the vaccine from any responsibility for ill effects.

10/23/11 Other ___/___/___ **Patient Signature** _____
(Parental signature required if less than 18 years)

Medical staff use only: Site: <input type="checkbox"/> RD <input type="checkbox"/> LD <input type="checkbox"/> NS <input type="checkbox"/> ID	Sanofi Pasteur FluZone/HighDose	Medimmune FluMist
Vaccinator Signature: _____	affix sticker here	affix sticker here

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Keeping Cape May County Healthy

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