579 Ringwood Avenue
Wanaque, New Jersey 07465

Municipal Building
Tel (973) 839-3000
Fax (973) 839-4959
Ext. 7124 or 7122

INFORMED CONSENT FOR RECEIPT OF INFLUENZA

I, _____, have read or had explained to me the attached information about influenza and the vaccines. I have had an opportunity to ask questions about influenza and the vaccines which were answered to my satisfaction.

To my knowledge, I am not allergic to chicken eggs or chicken egg products, yeast or Thimerosal (merthiolate) and have never been advised by my physician not to receive this vaccine. I am not allergic to epinephrin (adrenaline) or Benadryl (diphenhydramine), the drugs used to counteract an allergic reaction to a flu shot.

If I am taking Coumadin or another prescription blood thinner I have obtained my physician's consent to receive vaccine. If I take any steroid or chemotherapy I have consulted with my physician and have brought a Dr.'s order.

I do not currently have a fever or the symptoms of an acute infection. I have had no chemotherapy within the last 14 days and will have no chemotherapy until after 14 days. I have never been paralyzed with Guillain-Barre Syndrome.

I understand that the recommended immunization is one injection/dose at present. I further understand that if I have a condition of (or am undergoing treatment which causes) immunosuppression, the effectiveness of the vaccine in preventing the influenza may be diminished. I believe I understand the risks and benefits of the vaccine.

I agree to receive the influenza vaccines and I hereby release the Wanaque Health Department from any liability due to the administration and/or my receipt of this vaccine.

I understand that it is my responsibility to remain in the vaccine area for at least 15 minutes after I receive the vaccine, in case I experience a reaction. An R.N. will answer questions if I call with a reaction at 973-839-3000 Ext. 7124 and leave a message. An R.N. will listen to the voice mail every two hours after the clinic into the next day. Office Hrs.: Mon- Fri 9:00- 4:30p.m.

I agree that the information given by me in applying for payment under Title XVIII Medicare B.is correct. I have no HMO for medicare extension of benefits.

I authorize release of all medical records or the information about me to Medicare as needed and their authorized agents required to act on this request. I request payment of authorized benefits be made from Medicare on my behalf to the Wanaque Health Department.

Medicare Eligibility (Flu **ONLY**) #_____

I hereby certify I am not covered by an HMO for this procedure.

Signature_____Date:_____

Mailing Address: _____

Phone: _____ Birthdate: _____