Medicare Processing-
Form Number:
Initial:

WEST WINDSOR TOWNSHIP HEALTH DEPARTMENT
INFLUENZA VACCINATION APPLICATION

Please PRINT Clearly:

Last Name: _____ First Name: _____ M.I.:_____

Address: _____

City: _____ State: NJ Zip: _____

Phone:_____ Gender: _____ Date of Birth: _____

Part B Members Only:

MEDICARE #: _____Part B Effective Date: _____

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

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

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 me or 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. If eligible for Medicare Part B, I have provided my coverage information above and authorize West Windsor Township to file with Medicare for eligible benefits on my behalf.

_____ _____

Signature *Date*

For Official Use Only

Site Given: ☐ LA ☐ RA Lot # _____

Nurses Signature: _____ Date: _____

Clinic:_____