WASHINGTON TOWNSHIP
HEALTH DEPARTMENT

43 SCHOOLEY'S MOUNTAIN ROAD
LONG VALLEY, MORRIS COUNTY, NEW JERSEY

Telephone (908) 876-3650
Fax (908) 876-5138

Medicare Part B _____
Paid _____

HEALTH DEPARTMENT
INFLUENZA CONSENT FORM

Participant's Name (please print) _____

Home address (please print) _____

QUESTIONS:

1. Have you ever had a serious reaction to any vaccine? Yes ___ No ___
2. Are you allergic to eggs? Yes ___ No ___
3. Have you ever had Guillain-Barre Syndrome or any other neurological disorder? Yes___ No ___
4. Are you pregnant or nursing? Yes ___ No ___
5. Are you feeling ill today? Yes ___ No ___
6. Are you taking Coumadin, Dilantin, Plavix or Theophylline? Yes ___ No___
7. Do you have a sensitivity to latex? Yes ___ No ___

POSSIBLE SIDE EFFECTS:

Most people have no side effects to the flu shot. The most common reaction is soreness at the injection site for a day or two. Occasionally, people may experience a fever or muscle aches for one or two days. As with any drug or vaccine there is a possibility that an allergic reaction could occur.

I HAVE READ THE INFORMATION SHEET ABOUT THE INFLUENZA VACCINE. I HAVE HAD THE CHANCE TO ASK QUESTIONS WHICH WERE ANSWERED TO MY SATISFACTION AND I UNDERSTAND THE BENEFITS AND RISKS OF THE VACCINATION AS DESCRIBED. I REQUEST THAT THE INFLUENZA VACCINE BE ADMINISTERED TO ME.

_____ Date: _____
Signature of participant

_____ Site: _____
Signature of vaccinator

Afluris QIV PFS: *Seqirus*
Lot # P1002 58585
Exp. June 30, 2021

- ***Remember to read and sign reverse side of the page.***

WASHINGTON TOWNSHIP HEALTH DEPARTMENT
CONSENT AND HOLD HARMLESS

I, _____, sign this Hold Harmless as my voluntary act and by this act agree to hold directors, officers, agents, volunteers and employees of the Township of Washington, County of Morris and the Township of Washington Board of Health from any claims, suits, or other actions arising from, caused by or which are the alleged result of any act or omission of any Township employee or volunteer in connection with the activities of the FLU CLINIC performed by the Washington Township Health Department.

I HAVE READ THE INFORMATION SHEET ON INFLUENZA. I HAVE HAD THE CHANCE TO ASK QUESTIONS WHICH WERE ANSWERED TO MY SATISFACTION AND I UNDERSTAND THAT THE FLU VACCINATIONS ARE NOT OFFERED IN LIEU OF TREATMENT BY A MEDICAL DOCTOR.

Signed: _____ Date: _____

Witness: _____ Date: _____

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COVID19 QUESTIONS:

1. Within the past 14 days have you traveled out of the country, or to a state that has been designated as having significant community spread?

2. Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 10 minutes) with a person who is known to have laboratory confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?

3. Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?

4. Are you currently waiting for results of a COVID19 Test?

5. Have you experienced any of the following symptoms in the last 48 hours?
   Fever / Chills
   Cough
   Shortness of breath / difficulty breathing
   Fatigue
   Muscle or body aches
   Headache
   New loss of taste or smell
   Sore throat
   Congestion or runny nose
   Nausea or vomiting
   Diarrhea