Bergenfield Health Department: Adult Vaccination Clinic Consent Form

Patient Name: _____ ***Birth Date***: ___/___/_____

Circle one: Male Female

Address: _____ City_____ State_____ Zip_____

Telephone Contact: _____

Screening Questions Prior To Vaccination:

1) Are you sick today? _____ Yes _____ No

2) Do you have any Allergies? _____ Yes _____ No
   Allergies:_____

3) Have you ever had a serious reaction after receiving a vaccination? _____ Yes _____ No

4) Do you have a chronic health condition?
   List:_____.

5) Do you have cancer or an immune system disorder? _____.

6) Do you take cortisone, prednisone or anti- cancer drugs? _____.

7) Have you had radiation treatments? _____.

8) Have you had a seizure or brain or nervous system problem? _____.

9) Are you pregnant? _____.

10) Have you received a blood transfusion or been given a gamma globulin or anti-viral drug in the last year? _____.

11) Have you received a vaccine in the last 4 weeks? _____.

I give consent to be vaccinated and to enter my vaccination record in the NJIIS system.

Patient Signature: _____ Today's Date: _____/_____/_____

Date of vaccination: ____/____/____ Site of vaccine: _____

Administered by:_____ Vaccine ID sticker:

NJIIS ID#: _____