Randolph and Rockaway Borough Health Department
2025-26 PEDIATRIC INFLUENZA VACCINE REGISTRATION FORM
PLEASE PRINT ALL INFO

	Staff Use Only
NJIIS #	
VFC	
Private INS	
FluZone Trivalent (Sanofi)	
FluLaval Trivalent (GSK)	

DATE:_____ **LOCATION:**_____

Child's Name:_____ **Gender: Male**_____**Female**_____

Date of Birth:_____ **Age:**_____ **Phone # :**_____

Ethnicity: Hispanic_____**Not Hispanic**_____**Race:**_____

Parent/Guardian Name: _____

Address:_____

City:_____ **State:_NJ___ Zip:**_____

Insurance Company:_____

Member ID_____ **Group ID**_____

Relationship to Insured: Self_____ **Dependent** _____

Insured Name **(If different)**_____ **Insured Date of Birth** _____

	YES	NO
Are you allergic to eggs?		
Do you have a fever today?		
Have you ever had Guillain-Barre Syndrome?		
Did you get the flu vaccine last year?		
Is this your first time to receive the flu vaccine (**under 9 years only**)		
Have you received chemo or radiation in the last 2 months? (**If yes, MD note is needed**)		
Do you have Health Insurance?		
Does your Health Insurance cover immunizations?		
NJ Family Care Plan A verified? (if applicable) (**staff verified date:**_____)		
Vaccine Information Sheet (VIS) given (**VIS date 1/31/25**)	X	

INFLUENZA VACCINE CONSENT

I have received and read the information about influenza disease, the vaccine and special precautions. I have had an opportunity to ask questions that have been answered to my satisfaction. The 2025 Flulaval, Fluad and Fluzone (egg based) vaccine consists of: **A/Victoria/4897/2022 (H1N1), A/Croatia/10136RV/2023 (H3N2) & B/Austria/1359417/2021 (B/Victoria lineage).** The 2025 Flublok (Cell/recombinant based) consists of **A/Wisconsin/67/2022 (H1N1), A/District of Columbia/27/2023 (H3N2) & B/Austria/1359417/2021 (B/Victoria lineage).** I believe 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 of whom I am the parent, guardian or authorized person. I release the Randolph and Rockaway Borough Health Departments from any responsibility for my own health care needs, or liability from health consequences that may occur from my participation in this program.

Signature:_____ Date:_____
Parent or Guardian

Influenza Vaccine Lot #:_____ (Manufacturer: GSK/Sanofi) Site: LA____ RA____ LT____ RT___

Administered by:_____PHN, RN

Kathy Maher, APN-C 09/2025