Randolph and Rockaway Borough Health Department

2025-26 INFLUENZA VACCINE CONSENT FORM

	Staff Use Only
NJIIS#	
Private Ins	
317 funds	
Employee	
FluZone Trivalent (Sanofi)	
FluLaval Trivalent (GSK)	
FluBlok Cellular Tri (Sanofi)	
FluAd Hi Trivalent (Seqirus)	
FluZone Hi Trivalent (Sanofi)	

DATE:_____ **LOCATION:**_____

Patient Name:_____

Address: _____

City: _____ **State:**__**NJ**_____ **Zip:** _____

Phone# _____ **Gender: Male** _____**Female**_____

Date of Birth_____ **Age**_____

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

Insurance Company:_____

Member ID_____ **Group ID**_____

Medicare ID# (MBI) **(If Applicable)** _____

Relationship to Insured: Self_____ **Spouse**_____ **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?		
Have you received chemo or radiation in the last 2 months? **(If yes, MD note is needed)**		
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: _____

Influenza Vaccine Lot #:_____ Manufacturer: Sanofi / GSK/ Seqirus

Site of Injection: Left arm_____ Right arm_____

Administered by:_____ PHN, RN

Kathleen Maher, APN-C
09/2025