DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH
Office of Public Health Nursing
201 Wheatsworth Road
Hamburg, New Jersey 07419
Telephone: (973) 579-0570
Fax: (973) 579-0571

INFLUENZA (FLU) VACCINE

REGISTRATION FORM/CONSENT 2022-2023 INFLUENZA SEASON
SUSSEX COUNTY DIVISION OF HEALTH / OFFICE OF PUBLIC HEALTH NURSING

PLEASE PRINT

NAME (last, first) ☐ Male ☐ Female ☐ Other

STREET

CITY STATE ZIP MUNI CODE

PHONE E-MAIL ADDRESS

DATE OF BIRTH AGE

BILL TO:
☐ Blue Cross/Blue Shield ☐ Medicare ☐ Private Pay

MEMBER ID#

I authorize the Sussex County Division of Health (SCDH) to release related information regarding the above mentioned person to third party payers and to bill for service rendered to me if applicable. I request my payer to pay SCDH directly for services rendered to me.

Signature **Date**

SERVICES RENDERED

✓	*IMMUNIZATIONS*	*DX*	*CPT*	*FEE*		✓	*ADMINISTRATION FEE*	*CPT*	*FEE*
	BCBS INSURANCE						**FLU IMMUNIZATION ADMINISTRATION**		
	Influenza 3+ years quad no preservative	Z23	90686	$19.45			BCBS Administration	G0008	$25.60
	Influenza High Dose	Z23	90694	$72.07					
	MEDICARE-ADULT								
	Influenza (Medicare)	Z23	90686	$21.52			Medicare Flu Administration	G0008	$33.15
	Influenza High Dose (Medicare)	Z23	90694	$71.68					

PRE-IMMUNIZATION QUESTIONNAIRE (Print form to answer the following questions)

Is the person to be vaccinated sick today?	YES	NO
Is the person to be vaccinated allergic to eggs or egg products?	YES	NO
Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	YES	NO
Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	YES	NO
Has the person to be vaccinated ever had Guillian-Barre syndrome?	YES	NO
Has the person to be vaccinated ever had an influenza vaccine in the past?	YES	NO

INFLUENZA VACCINE CONSENT (Flu vaccine)

I received and read the Vaccine Information Statement (VIS) about Influenza disease, the vaccine, and special precautions. I have had the opportunity to ask questions that have been answered to my satisfaction. I verify that my answers on the Pre-Immunization Questionnaire are correct to the best of my knowledge.
I understand the benefits and risks of the influenza vaccine as described. I request that the influenza vaccine be administered to me or to the person named for whom I am authorized to sign.

Signature **Date**

CLINIC DATE FORMS REVIEWED BY

COUNTY EMPLOYEE DEPARTMENT

VOLUNTEER/EMS

VIS 08/06/2021

For Vaccinator to complete:

Date:

Injection site (circle one): Left arm Right arm Other

Manufacturer & LOT# of vaccine

Print Name of Vaccinator _____Signature of Vaccinator_____