For anyone born before January 1, 1998
See reverse side for NJ Immunization Information System Participation Consent

Screening checklist for Contraindications to Inactivate Injectable Influenza Vaccination:

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child an inactivated influenza vaccination today. If you answer "yes" to any questions, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Is the person to be vaccinated sick?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to a component of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to an influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillian-Barré syndrome?	☐	☐	☐

I have read the Vaccination Information Sheet (VIS) or have had explained to me the information about the vaccine.

I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that the vaccine be given to me or to the person named below for whom I am authorized to make this request.

Name: _____
Last First MI

Address: _____

Date of Birth: _____ Contact number: _____

Email Address: _____

Signature of person to receive vaccine or person authorized to make the request:

X _____ Date: _____

FOR CLINIC USE ONLY

SITE: _____ Manufacturer: _____

Lot#: _____ Expiration Date: _____

Signature: _____ Date: _____

New Jersey Department of Health
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
609-826-4860 (Fax 609-826-4866)
www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

REGISTRANT INFORMATION	***PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)***
Registrant Name *(Print)*	Name *(Print)*
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider	Relationship to Registrant

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.

I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.

I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above.

There is no cost to participate in this program.

☐ Yes, I would like to participate in this program.

☐ No, I do not want to participate in this program.

Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number

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