Cape May County's Flu Vaccine Drive-Thru Clinics 13 Years and Older

Date: November 6, 2021
Time: 9:00 a.m.-1:00 p.m.
Location: Cape May County Fire Academy

Cape May County's Family Flu Vaccine Clinics 6 Months and Older

Date: Every Wednesday in October Starting October 6, 2021
Time: 1:00 p.m.-5:00 p.m.
Location: Cape May County Department of Health
6 Moore Road, CMCH, NJ 08210

Date: October 17, 2021
Time: 9:00 a.m.-2:00 p.m.
Location: St. Francis Cabrini Church
114 Atlantic Ave, Ocean City, NJ 08226

Date: October 21, 2021
Time: 3:00 p.m.-5:00 p.m.
Location: Upper Township Community Center
1790 NJ-50, Woodbine, NJ 08270

Date: October 26, 2021
Time:12:00 p.m.-2:00 p.m.
Location: Lower Township Senior Center
2612 Bayshore Road, Villas, NJ 08251

Date: October 26, 2021
Time: 3:00 p.m.-5:00 p.m.
Location: Lower Township Rec Center
2600 Bay Shore Road #1, Villas, NJ 08251

Date: October 28, 2021
Time: 3:00 p.m.-5:00 p.m.
Location: SOAR Church of Woodbine
1324 Dehirsch Ave, Woodbine, NJ 08270

Date: November 4, 2021
Time: 2:30 p.m.-5:00 p.m.
Location: Holly Beach Fire Co.
103 W Montgomery Ave, Wildwood, NJ 08260

Please fill out consent form prior to arriving
http://capemaycountynj.gov/622/Seasonal-Influenza

Wearing a mask is mandatory.

Regular and High Dose While Supplies Last

For Additional Information:

Visit: CMCHealth.net
Call:
English: (609) 465-1187
Spanish: (609) 465-6840
Like Cape May County Department of Health on Facebook

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Cape May County Flu Clinic
2021-2022 Patient Consent Form

Name:______________________________ DOB: ____/____/______ Age:______ Sex: ☐Male ☐Female

Home Address: ____________________________ City: ____________________ State: ____ Zip: _________

Telephone: __________________________

Print Guardians Name (if under 18 yr.) ____________________________________

Are you a healthcare worker or do you work in a long-term care facility?	☐Yes	☐No
Do you live with or take care of someone who is at high risk for influenza complications?	☐Yes	☐No
Did you get a flu vaccine last year?	☐Yes	☐No

VACCINE SCREENING QUESTIONS:	Yes	No	
Do you have a severe allergy to eggs or other vaccine component?	☐	☐	If YES, you must receive the flu vaccine from your doctor
Have you been diagnosed with Guillain-Barré syndrome?	☐	☐	
Do you have a severe allergy to Thimerosal?	☐	☐	If YES, Specify:
Have you ever had a serious reaction to a flu vaccine?	☐	☐	If YES, Specify:
Do you have a severe allergy to latex?	☐	☐	If YES, speak with the nurse
Have you come into close contact with someone who tested positive for COVID-19 in the past 14 days?	☐	☐	If YES, speak with the nurse
Do you feel sick?	☐	☐	If YES, speak with the nurse

I am electing to receive a vaccination against influenza. I am taking this vaccine voluntarily and consent to the vaccination being given to me. I have read the Vaccine Information Statement (8/06/21). I understand the risks and benefits of this vaccine. I have had an opportunity to ask questions which have been answered to my satisfaction. I hereby waive any claim for damages that I or anyone claiming on my behalf may have against the County, Health Department, clinic, employees and/or agents on account of any injury or misfortune I may suffer as a result of this vaccination. I further understand information may be entered into the New Jersey Immunization Information System.

Today's Date___/___/_____ **Patient Signature** ____

(Parental signature required if less than 18 years)

Today's Date___/___/_____ **Vaccine Administrator Signature**____________________________

Medical staff use only: Site: ☐ RD ☐ LD	GSK/Sanofi/Seqirus
Affix sticker here	

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Cape May County Department of Health
Keeping Cape May County Healthy

Cape May County
Clínicas para Vacunas Contra la Gripe (Flu)

2021-2022 Formulario de Registración

Nombre: ______________________________ Fecha de Nacimiento: ____/____/_____ Edad: _______ ☐Hombre ☐Mujer

Dirección: ___________________________________ Ciudad: _______________ Estado: ______ Código postal: ___________

Teléfono: ____

(Si es menor de 18 años) Nombre del representante____

¿Es Ud. un profesional de salud o trabaja en un ancianato, u otra institución? ☐Sí ☐No
¿Vive Ud. con, o cuida a personas con alto riesgo de complicaciones a causa de la gripe (flu)? ☐Sí ☐No
¿Recibió Ud. la vacuna contra la gripe (flu) el año pasado? ☐Sí ☐No

PREGUNTAS DE EVALUACION:	**Sí**		**No**	
¿Tiene Ud. una alergia grave a los huevos o a cualquier otro componente de la vacuna?	☐		☐	**SI: Ud. debe recibir la vacuna su médico**
¿Ha sido diagnosticado con el síndrome de Guillain-Barré?	☐		☐	
¿Tiene Ud. una alergia grave al Thimerosal?	☐		☐	**SI: especifique:**
¿Alguna vez ha tenido una reacción grave a la vacuna del flu?	☐		☐	**SI: especifique:**
¿Tiene Ud. una alergia grave al látex?	☐		☐	**SI: hable con la enfermera**
¿Ha estado en contacto cercano con alguien que dio positivo a COVID en los últimos 14 días?	☐		☐	**SI: hable con la enfermera**
¿Se siente enfermo hoy?	☐		☐	**SI: hable con la enfermera**

He elegido recibir la vacuna contra la influenza. Lo hago de forma voluntaria y consiento que me sea dada. He leído la información Declaración (8/6/21). Entiendo los riesgos y los beneficios de esta vacuna. He tenido la oportunidad de hacer preguntas las cuales han sido respondidas a mi satisfacción. Por este medio estoy exonerando el Condado, Departamento de Salud, Clínica. Empleados y/o agentes de alguna reclamación en su contra que pueda hacer yo o alguien más en mi nombre por daños o perjuicios que pueda sufrir como resultado de esta vacuna. Además, entiendo que mi información será entrada al Sistema de Inmunización de New Jersey.

☐**Otro ___/___/_____** **Firma** ____

(Se requiere la firma del padre si tiene menos de 18 años)

☐**Otro ___/___/_____** **Firma del administrador de la Vacuna** ____________________________________

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affix sticker here	

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