



Borough of Fair Lawn
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HEALTH DEPARTMENT
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 Health Officer

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INFORMATION CONCERNING PERSON TO RECEIVE THE H1N1 VACCINE

Name _____
 Last Name MI First name Date of Birth Age

Address _____ Gender _____
 Male Female

City _____ County _____ State _____ Zip _____ Home\Cell Number: _____

Parent\Guardian Name _____
 Last Name MI First Name

Mother Father Guardian Home\Cell Number _____

Address _____ City _____ State _____ Zip _____

Consent for Vaccination

I have read the H1N1 Information Statement dated 10/2/09 and have had an opportunity to ask questions. I understand the benefits and risk of flu vaccination as described. I request that the vaccine be given to me or the person named above for whom I am authorized to sign. I do hereby release and forever discharge the Fair Lawn Health Department, Fair Lawn Mayor & Council and/or its employees and volunteers from any and all liability in connection with the inoculation, or any suits, damages, claims, or demands, if any, arising from said inoculation.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I am aware and accept that the Fair Lawn Health Department may use and disclose my vaccination information provided herein to the NJIIs (New Jersey Immunization Information System).

 Signature of Person to Receive Vaccine
 Or Guardian

 Today's Date

INJECTABLE VACCINE						
Date Administered	IM Route/Site	Dose Number (1 st or 2 nd)	Vaccine Manufacturer	Lot Number	Expiration Date	Staff Initial
	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Arm <input type="checkbox"/> Leg					
FLU MIST VACCINE (by nose)						
Date Administered	Dose Number (1 st or 2 nd)	Vaccine Manufacturer		Lot Number	Expiration Date	Staff Initial

