

Check list for 2018 Flu Vaccination Programs

1	Making Draft of Flu Vaccination Press Release 2018		
2	Schedule for Adult Vaccination Sites		
3	Schedule for Daycare Vaccination Sites		
4	Securing Medical Care Services Staff RNs		
5	Securing and assigning Immunization Office Staff	two Clerical and two RN staff will go to sites	
6	Informing the Schedules to Adult Sites		
7	Informing the Schedules to Children Sites		
8	Booking rooms for City DHCW sites		
9	Fill out form to book Newark Public library		
10	Inventory of Vaccines for children 3 and over (GSK : 2500 doses)	FLUARIX® QUADRIVALENT	
11	Inventory of Vaccines for Adults 65 and under(GSK : 2500 doses)		
12	Consent Forms (Copies)		
13	Securing City Transports, Drivers and Gas		
14	Vaccine Transporting Containers, Ice Packs		
15	Vaccination Sites Confirming (space, table, chairs) with Previsit,		
16	Entering Data into NJIS (following day)	Following day at 110 William St.	
17	Giveaways (Bag with tooth brush , paste and crayons) Evelyn		

ATTACHMENT A

City of Newark- Dept. of Health and Community Wellness



Influenza Pediatric Consent Form (IM Administration)

Date: / /		Location:	
Child's Name:		Age:	Sex:
Parent/ Guardian's Name:		Relationship:	
Address:		Phone #:	
City:		State:	Zip:
Insurance:		Date of Birth:	

1. Is your child allergic to eggs, egg protein, gentamicin, gelatin or arginine?	<input type="checkbox"/> NO <input type="checkbox"/> YES
2. Has your child ever had a life threatening reaction to any flu vaccine?	<input type="checkbox"/> NO <input type="checkbox"/> YES
3. Did your child ever have weakness or loss of sensation in a body part (Guillain-Barre syndrome)?	<input type="checkbox"/> NO <input type="checkbox"/> YES
> Has your child ever received a flu vaccine? <input type="checkbox"/> YES <input type="checkbox"/> NO > How many doses of the flu vaccine has your child received? _____ If your child has never received a flu vaccine before or received only 1 dose the first time he/she was vaccinated, and he/she is under age 9, your child should get a second dose of flu vaccine in approximately 4 weeks.	

Influenza Consent

I have received and read the Vaccine Information Statement about inactivated influenza vaccine. I have reviewed the reasons some children should not get the vaccine. None of these reasons apply to my child. I agree to have my child vaccinated with the flu vaccine and with a second dose, if indicated. I authorize the release of any medical or other information necessary to process a Medicaid or other insurance claim or for other public health purpose. I hereby release DCFWB, their employees, directors and officers from any accident, act of omission or commission, which arises during vaccination. This consent is valid for 6 months and maybe used to administer a 2nd dose of influenza in 4 weeks.

Signature of recipient (parent/guardian) _____ Date _____

FOR STAFF USE ONLY			
1 st Dose		2 nd Dose	
Temperature:	Wt:	Temperature:	Wt:
Check here <input type="checkbox"/> if administration info is recorded on chart vaccine log in lieu of here.		Check here <input type="checkbox"/> if administration info is recorded on chart vaccine log in lieu of here.	
Signature/title:		Signature/title:	
Injection Site:		Injection Site:	
Manufacturer: _____		Manufacturer: _____	
Lot # _____ Expiration Date _____		Lot # _____ Expiration Date _____	

PH101 Attachment B MCS 2015-16

ATTACHMENT B1

Influenza / Pneumococcal Vaccination Consent Form

Date:	Location: DHCW		
Name:	Age:	Sex:	Race:
Address:	Phone #:		
City:	State: NJ	Zip:	
Medicare #:	Medicaid #:		
Social Security:	Date of Birth:		

- | | | | |
|--|-----------------------------|------------------------------|---------------------|
| 1. Are you allergic to eggs? | <input type="checkbox"/> NO | <input type="checkbox"/> YES | |
| 2. Do you take blood thinners? | <input type="checkbox"/> NO | <input type="checkbox"/> YES | |
| 3. Do you have a chronic medical condition? | <input type="checkbox"/> NO | <input type="checkbox"/> YES | If Yes, what? _____ |
| 4. Have you ever had a serious reaction to a flu shot? | <input type="checkbox"/> NO | <input type="checkbox"/> YES | |
| 5. Are you allergic to latex or rubber? | <input type="checkbox"/> NO | <input type="checkbox"/> YES | |
| 6. Are you sick with fever? | <input type="checkbox"/> NO | <input type="checkbox"/> YES | |
| 7. Are you pregnant? | <input type="checkbox"/> NO | <input type="checkbox"/> YES | |
| 8. Have you ever had a Guillian Barre Syndrome? | <input type="checkbox"/> NO | <input type="checkbox"/> YES | |
| 9. Do you have close contact with anyone with a Weakened immune system? | <input type="checkbox"/> NO | <input type="checkbox"/> YES | |
| 10. Are you currently receiving radiation, chemotherapy, or immunosuppressive therapy? | <input type="checkbox"/> NO | <input type="checkbox"/> YES | |
| 11. Have you ever received a pneumonia shot? | <input type="checkbox"/> NO | <input type="checkbox"/> YES | If Yes, date: _____ |
| 12. Is this your (your child's) first time getting the flu vaccine? | <input type="checkbox"/> NO | <input type="checkbox"/> YES | |

Influenza Consent

I have read, or had explained to me, the information sheet about Influenza vaccination. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I request that the Influenza vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose.

Signature of recipient (parent/guardian) Date

Pneumococcal Consent

I have read, or had explained to me, the information sheet about pneumococcal vaccination. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I request that the pneumococcal vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose.

Signature of recipient (parent/guardian) Date

Influenza Vaccine

Administration Site: Left arm Right arm
 Dosage: 0.5 mL 0.25 mL
 Temp: _____
 Manufacturer & Lot Number: _____

I have reviewed side effects with patient (parent/guardian)
 Nurse Signature: _____

Pneumococcal Vaccine

Administration Site: Left arm Right arm
 Temp: _____
 Manufacturer & Lot Number: _____
 Indication for Pneumococcal Vaccine if under 65: _____

I have reviewed side effects with patient (parent/guardian)
 Nurse Signature: _____

2018 Community Vaccination Contacts

Site	Address	Contact Name	Title	Email	Phone

ATTACHMENT C 1

2018 Day Care Vaccination Contacts

Site	Address	Contact Name	Title	Email	Phone

ATTACHMENT C2

October - December 2018 Influenza Vaccination Schedules

Month	Date	Time	Flu Sites	Address	Ward	Nurse	Flu Vacc #
October							
November							
December							
Totals:							

ATTACHMENT D

2018 Community Vaccination Confirmation Dates

Site	Address	Date assigned	# of Children	# of Staff	Email	Phone

2018 Day Care Vaccination Confirmation Dates

Site	Address	Date assigned	# of Children	# of Staff	Email	Phone

ATTACHMENT E2

Newark, NJ
2018 Seasonal Flu (Influenza) Vaccination Program

It is time for flu (influenza) shots again. Flu season is around the corner. Getting the flu vaccine is the best way to protect against the flu. Influenza virus changes every year, so it is important to get vaccinated each and every year. Flu virus can strike both healthy and sick, and the young and the old. It is important to protect our won health and health of those around us. You risk infecting your friends, family and coworkers by not getting a flu shot, so please get your flu shot!

— Mayor _____ announced today that _____ will provide free influenza vaccinations for Newark residents, throughout the City during the year. “The fall season is the time when families should ask their healthcare providers about getting the annual flu shot” said Mayor _____. He further said “I urge all residents, especially our residents with chronic medical conditions such as asthma, diabetes, lung or heart disease, which are most vulnerable to the flu virus, to protect themselves by taking advantage of these free vaccinations for flu prevention”.

“_____ residents’ should get their flu shots to ensure their physical health and well-being during this season. We are offering free flu shots at various locations throughout the City beginning October _____, 2018 and encourage all Newark residents to take advantage of this service. Protect yourself, your children, and your community by doing your part to reduce the spread of the disease,” said the Mayor.

The 2018 Seasonal Influenza Vaccination Program is provided by the Department of Health and Community Wellness. Flu shots will be given at various sites on scheduled days and times, please see list of sites below. Residents seeking the shots must bring proof of address.

From October to April, 2019, the Department of Health and Community Wellness will administer vaccinations at their clinics located at 110 William Street and 394 University Avenue, Monday-Friday from 8:30 a.m. to 4:00 p.m.

Dr. _____, Director, Department of Health and Community Wellness states “let’s keep Newark healthy and avoid sick days at work and school absenteeism. Our workforce and children’s education are essential factors in the success and growth of our City and economy. You can contribute to these efforts by maintaining healthy lifestyles and ensuring that your families get the flu shot early to prevent influenza in the communities”.

For more information regarding the 2018 Seasonal Influenza Vaccination Program, contact Velda Font-Morris, MPH Immunization Coordinator, Department of Health and Community Wellness at 973-733-7643 or the Division of Surveillance and Prevention at (973) 733-7592.