



# Putnam County Department of Health

## Influenza Immunization Consent Form



Name (please print)	Date of Birth	Age	Date of Immunization
Address	City	State	Zip
Clinic/Office Site Where Vaccine is Administered	Sex (please circle) Male                  Female	Phone	
Doctor's Name and Address	NYS Immunization Information System (19 & older only) <input type="checkbox"/> NO <input type="checkbox"/> YES	Medicare Claim Number	

- Are you sick with fever?  NO    YES
- Is this your first time getting the flu shot?  NO    YES
- Have you ever had a severe life threatening allergic reaction to influenza vaccine?  NO    YES
- Are you pregnant?  NO    YES
- Have you ever had Guillain Barre syndrome?  NO    YES
- Do you have a severe allergy to eggs, latex, thimerosal or gelatin?  NO    YES
- If Yes, Which one? \_\_\_\_\_

**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 or guardian)

\_\_\_\_\_  
Date

Area Below to be Completed by Nurse

**Influenza Vaccine:**

**Administration Site:**     Left arm     Right arm     Left Thigh     Right Thigh

**Dosage :**                     0.5 ml                     0.25 ml                    Next Immunization Due:  Next Year     in 4 weeks

Manufacturer & Lot Number \_\_\_\_\_                    VIS Date :    8/7/15

I have reviewed side effects with patient (parent or guardian)                    Nurse Signature \_\_\_\_\_