PUTNAM COUNTY DEPARTMENT OF HEALTH
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www.putnamcountyny.gov/health
A PHAB-ACCREDITED HEALTH DEPARTMENT

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 select) ☐ Male ☐ Female	Phone
Doctor's Name and Address	NYS Immunization Information System (19 & older only) ☐ NO ☐ 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 : ❑ 0.7ml ❑ 0.5 ml Next Immunization Due: ❑ Next Year ❑ in 4 weeks

Manufacturer & Lot Number _____ VIS Date : 8/15/19

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