



## PUTNAM COUNTY DEPARTMENT OF HEALTH

1 Geneva Road, Brewster, NY 10509 ■ 845-808-1390

[www.putnamcountyny.gov/health](http://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 Male                  Female	Phone	
Doctor's Name and Address	NYS Immunization Information System (19 & older only) YES                  NO	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

Manufacturer and Lot # : \_\_\_\_\_

VIS Date: 1/31/25

Next Immunization Due: ☐ Next Year ☐ in 4 weeks

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

Nurse Signature \_\_\_\_\_