



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 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: 8/6/2021

Next Immunization Due: Next Year in 4 weeks

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

Nurse Signature _____