PUTNAM COUNTY DEPARTMENT OF HEALTH
1 Geneva Road, Brewster, NY 10509 ■ 845-808-1390
www.putnamcountyny.gov/health
A PHAB-ACCREDITED HEALTH DEPARTMENT

INFLUENZA IMMUNIZATION CONSENT FORM

Name (please print)	Date of Birth	Age	Date of Flu Clinic

Address	City	State	Zip

Grade/Teacher	Sex ☐Male ☐Female	Phone (where parent can be reached on day of clinic)

School: MPES 10/5/23 KES 10/13/23 KPS 10/13/23
GFMS 10/17/23 Carmel HS 10/19/23

NYSIIS Consent (**for those 19 & older ONLY**)
(Teachers and Staff) ☐ YES ☐

Is this your first time getting the flu shot? ☐ NO ☐ YES

Have you ever had a severe life threatening allergic reaction to a flu shot? ☐ 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? _____

SEASONAL INFLUENZA CONSENT I have read the information sheet about seasonal influenza vaccination. I understand the benefits and risks of the vaccination as described. I request that the seasonal influenza vaccination be given to the patient named above. I authorize the release of any medical or other information necessary for public health purposes.

_____
Name of recipient (parent or guardian) Signature Date

Area Below to be Completed by Nurse

Are you sick with fever today? (To be completed by nurse on day of clinic) ☐ NO ☐ YES

VIS Date: 8/6/21 Manufacturer & Lot Number Sanofi-Pasteur Exp. 6/30/24

Administration Site: ❑ Left arm ❑ Right arm

Reviewed and Administered by: _____ Date: _____
Nurse Signature