



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	Putnam Valley Elementary 9/29/23 Putnam Valley High 9/27/23 Putnam Valley Middle School 9/27/23		NYSIIS Consent (for those 19 & older ONLY) (Teachers and Staff) <input type="checkbox"/> YES <input type="checkbox"/> NO	

- 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