



**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 High 10/8/24      Putnam Valley Middle School 10/8/24 Putnam Valley Elementary 10/11/24	NYSIIS Consent ( <b>for those 19 &amp; older ONLY</b> ) (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 U8435AA      Exp. 6/30/25

**Administration Site:**    Left arm    Right arm

Reviewed and Administered by: \_\_\_\_\_ Date: \_\_\_\_\_  
Nurse Signature