Putnam County Health Department

Flu Assessment Screening and Consent Form

Please *PRINT* **Age:_____**

Name:_____ **Date of Birth:**_____
First Middle Last

Address:_____ **Phone#:**_____
Street

County: _____
City State Zip Code

Please circle:

Male or Female **Insured or Uninsured**

If Applicable: Medicare #:_____
(Entire number including Letters)

Medicaid #: _____

Please answer the following question: (If answer yes, please explain.)

1. Are you sick today? **Yes or No**_____
2. Do you have any allergies? **Yes or No** _____
3. Have you had a reaction to Influenza vaccine before? **Yes or No** _____
4. Have you ever been diagnosed with Guillain-Barre` Syndrome? **Yes or No** _____
5. Are you pregnant? **Yes or No** _____

I acknowledge by my signature below, that I have been offered a copy of Putnam County Health Department's "Notice of Privacy Practice Act (HIPAA)". I understand that if I have Medicare or Medicaid insurance, the insurance will be billed for the vaccine and injection. I have read the statements above. _____
Initials

Please read the following statement

This Clinic will keep this record in the Putnam County Health Department file. This will record when the vaccine was given, the name of the company that made the vaccine, the vaccine lot number and who and where vaccine was given. I have read and or received a copy of the Vaccine Information Statement(s) for the vaccine(s) indicated below. I have had a chance to ask questions and have them answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine for which I have signed below, be given to me or the person named above for whom I am authorized pursuant to Section 431.058 to make this request.

_____ _____
Signature of Patient or Parent/Guardian **Date**

**********FOR CLINIC USE ONLY**********

Patient recommended for vaccine unless otherwise designated.

_____ **No vaccine given** _____ **Referred for further medical screening**

Fluzone Quadrivalent	**Fluzone High Dose**
Sanofi Pasteur Inc. Lot # _____ Expiration date: 06/30/2024 Site of Injection: 0.5 mL Right Left Deltoid	Sanofi Pasteur Inc. Lot # _____ Expiration date: 06/30/2024 Site of Injection: 0.7mL PFS Right Left Deltoid

Date VIS & Vaccine Given: _____

Given by: _____
(signature/credentials)