PUTNAM COUNTY
HEALTH DEPARTMENT

2026-2027 Flu Screening and Consent Form
Phone: (660)947-2429

Please *PRINT* **Age:**_____

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

Address:_____ Phone#:_____
Street

_____ County: _____
City *State* *Zip Code*

Gender: ___ Male ___ Female

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

Medicare Advantage #: _____

Please answer the following questions: (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 a copy has been made available to me of the Vaccine Information Statement(s) for the vaccine. 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

2026-2027 Fluzone *6 months – 64 years*	**2026-2027 Fluzone High-Dose** *65 years & older*
Manufacturer: Sanofi Pasteur Inc. Lot #: Expiration date: 06/30/2027 VIS Revision Date: 01/31/2025 Site of Injection: 0.5 mL deltoid PFS Right Left	Manufacturer: Sanofi Pasteur Inc. Lot #: Expiration date: 06/30/2027 VIS Revision Date: 01/31/2025 Site of Injection: 0.5 mL deltoid PFS Right Left

Date VIS & Vaccine Given: _____

Given by: _____
(signature/credentials)