MONROE COUNTY HEALTH DEPARTMENT

ADULT Annual Influenza Vaccine Consent Form 2019-2020

Section 1: Information about Person to Receive Vaccine (please print)

NAME (Last)	(First)	(Middle initial)	DATE OF BIRTH month_____ day____ year_____
STREET ADDRESS	AGE	GENDER MALE FEMALE	
CITY STATE	ZIP	PHONE	

Section 2: Vaccination Fee –(Check only ONE box) -

☐ **I am enrolled in Medicaid. Medicaid #: _____**

☐ **I am enrolled in Medicare (primary ins) Medicare # & letters: _____**

☐ **I have private insurance = Vaccination Fee $25; High Dose option for over age 19= $55**

Section 3: Screening for Vaccine Eligibility: MUST answer YES or NO for each question.

1. Do you have any of the following: **asthma, diabetes** (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood or weakened immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	**YES**	**NO**
2. Do you have an allergy to eggs?	YES	NO
3. Do you have any other serious allergies? Please list: _____	YES	NO
4. Have you ever had a serious reaction to a previous dose of flu vaccine?	YES	NO
5. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	YES	NO
6. Have you been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month_____ day_____ year_____	YES	NO
7. Do you take daily aspirin or on aspirin-containing therapy?	YES	NO
8. Are you receiving influenza antiviral medications?	YES	NO
9. Are you pregnant?	YES	NO

Section 4: CONSENT FOR VACCINATION:

I have read or had explained to me the 2019-2020 Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits. By signing this consent form below, **I GIVE CONSENT** to the MONROE COUNTY HEALTH DEPARTMENT and its staff for the person named at the top of this form to be vaccinated with this vaccine. (If this consent form is not signed, then person will not be vaccinated)

Signature of Patient: _____ Date: month____ day____ year____

Section 5: Vaccination Record FOR ADMINISTRATIVE USE ONLY

Influenza Vaccine	Route	Date Dose Administered	Site	Lot Number/Exp.	Name and Title of Vaccine Administrator
FLU FluBlok HD	IM		Deltoid R L		