

MONROE COUNTY HEALTH DEPARTMENT
Adult Annual Influenza Vaccine Consent Form 2023-2024

Section 1: Information about Person to Receive Vaccine (PLEASE PRINT)

NAME (Last)		(First)		DATE OF BIRTH Month _____ Day _____ Year _____	
STREET ADDRESS			AGE	GENDER AT BIRTH MALE FEMALE	
City	State	Zip Code	Phone		

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

- ☐ **MEDICARE Numbers & Letters (NO SUPPLEMENTS):** _____
- ☐ **MEDICAID Number:** _____
- ☐ **PRIVATE PAY = Vaccination Fee: Standard \$35; High Dose (65 years & above) \$75**

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 types of metabolic disease), disease of the lungs, heart, kidneys, liver, nerves, blood or weakened immune system? (Example: HIV, cancer, 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 are you on aspirin-containing therapy?	YES	NO
8. Are you receiving antiviral medications? (Example: Paxlovid, Valtrex, Tamiflu, Relenza, etc.)	YES	NO
9. Are you pregnant?	YES	NO
10. Are you sick today?	YES	NO
11. Have you received a positive Covid test in the past 10 days?	YES	NO
12. Do you have a history of fainting/passing out from needles or shots?	YES	NO

Section 4: CONSENT FOR VACCINATION:

I have read or had explained to me the 2023-2024 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. **CONSENT FORM MUST BE SIGNED.**

Signature of Patient _____ Date: month _____ day _____ year _____

Section 5: Vaccination Record -FOR ADMINISTRATIVE USE ONLY

VIS Date: _____

Influenza Vaccine	Route	Date Dose Administered & VIS Given	Site	Lot Number	Name and Title of Vaccine Administrator
FLU High Dose	IM		Deltoid R L		