FLU 24/25 **MONROE COUNTY HEALTH DEPARTMENT**

Adult Annual Influenza Vaccine Consent Form 2024-2025

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; FluBlok (18 years & older) $75**

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

	YES	NO
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) Are you a solid organ recipient?		
2. Do you have any other serious allergies? Please list: _____	YES	NO
3. Have you ever had a serious reaction to a previous dose of flu vaccine?	YES	NO
4. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	YES	NO
5. Have you been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: Month ____ Day ____ Year _____	YES	NO
6. Do you take daily aspirin or are you on aspirin-containing therapy?	YES	NO
7. Are you receiving antiviral medications? (Example: Paxlovid, Valtrex, Tamiflu, Relenza, etc.)	YES	NO
8. Are you pregnant?	YES	NO
9. Are you sick today?	YES	NO
10. 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 2024-2025 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 given at time of visit.

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