MD_____ HW_____
MC_____ CA_____

GREENWOOD COUNTY HEALTH DEPARTMENT
CONSENT FOR INFLUENZA VACCINATION

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	BIRTHDATE	AGE
RACE: ☐ WHITE ☐ BLACK ☐ MEXICAN ☐ INDIAN ☐ OTHER_____			_____MALE _____FEMALE
STREET ADDRESS		PHONE	
CITY	STATE	COUNTY	ZIP CODE
MEDICARE NUMBER			

1. Are you sick today? _____yes _____ no
2. Do you have allergies to eggs or neomycin? _____yes _____ no
3. Have you ever had a serious reaction after receiving a vaccine? _____yes _____ no
4. Have you been diagnosed with Guillain Barre' syndrome? _____yes _____ no

I have read or been offered the "Vaccine Information Statement" (VIS). I give permission to have the following vaccination done under the direction of Greenwood County Health Department. By signing below, I also acknowledge that Greenwood County Health Department has offered me a copy of their Privacy Practices.

X _____ _____

SIGNATURE OF PERSON RECEIVING OR AUTHORIZING VACCINE DATE

FOR CLINICAL USE ONLY BELOW THIS LINE

PROVIDERVACCINE	CLINIC SITE
GREENWOOD COUNTY HEALTH DEPT.	
STREET ADDRESS / PHONE	STATE / ZIP CODE
200 W. 1st PHONE (620) 583-6632	KANSAS 67045
INFLUENZA	
SITE OF INJECTION (Circle Site Below)	SITE OF INJECTION (Circle Site Below)
RIGHT DELTOID LEFT DELTOID	RIGHT DELTOID LEFT DELTOID
Vaccine Given Below	Vaccine Given Below
MANUFACTURER & LOT # / Expiration Date	MANUFACTURER & LOT # / Expiration Date

_____ _____

SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR DATE VACCINATED

SEE OTHER SIDE FOR DRIVE-THRU FLU CLINIC ROUTE