INFLUENZA (BILLABLE)

I have received and read the Vaccine Information Statement (VIS) about the influenza and influenza vaccine and I have had a chance to ask questions. I understand the benefits and risks of this vaccination and request that the vaccine be given to me or the person named below for whom I am authorized to sign. I furthermore release Warren County Public Health Department and any other organizational site associated with influenza vaccine administration from all liability arising from this vaccine.

PLEASE PRINT!

Name ______________________________ **Gender:** ____ **Male** ____ **Female**

Date of Birth:______________________ **Age:**________ **Phone #:** ________________________

Street Address______________________________ **Insurance:** _____yes ______no

Type: ______________________________

City ______________________ **State**______ **Zip**__________

Warren County Resident ________Y/N

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SIGN NAME (Person receiving vaccine or Parent or Guardian)

PRINT NAME ______________________________

MEDICARE #______________________________

FOR CLINIC USE ONLY

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Clinic Site: ________________________

Date: ____________ Injection Site: __________

Administered by: ________________________

Manufacturer: ________________________

Lot #: ________________

Expiration: ______________

TYPE OF INSURANCE: ______________________

VIS TAKEN______ **DATE**_______ **VIS REFUSED**_____

VIS DATE: 8/6/21