

## CONSENT

I have read the CDC's information about the influenza and influenza vaccine and I have had a chance to ask questions. I understand the benefits and risks of influenza 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 Nursing Agency and any other organization associated with influenza vaccine from any and all liability arising from this treatment. I have received Warren County Public Health Nursing Agency's Notice of Privacy Practices and Vaccine Information Statement (dated 7/16/07).

### Information - Person to Receive Vaccine (PLEASE PRINT)

Name \_\_\_\_\_ Gender: \_\_\_ Male \_\_\_ Female

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Phone #: \_\_\_\_\_

Street Address \_\_\_\_\_ Medicare #: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ (Only if you have Part B and it is NOT an HMO)

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Warren County Public Health Nursing Agency any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the CMS (formerly known as Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services."

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**Signature (Person receiving vaccine or Parent or Guardian)**

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### FOR CLINIC USE ONLY

Name of Clinic: \_\_\_\_\_

Date: \_\_\_\_\_

Injection Site: \_\_\_\_\_

Administered by: \_\_\_\_\_

Manufacturer: Sanofi Pasteur

Lot #: \_\_\_\_\_ Expiration: June 30, 2008