

ADULT AGES 50 – 64 FLU AND PNEUMONIA VACCINE CONSENT

2011-2012

ODH	<input type="checkbox"/>
Private	<input type="checkbox"/>

Consent for Vaccine Administration:

I have read or have had explained to me the information on the 7/26/11 Influenza and/or 10/06/09 Pneumococcal Vaccine Information Statement. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government health benefits to the Medina County Health Department who accepts assignment. I have read or been given a copy of the Medina County Health Department's Notice of Privacy Practices. I have been given the opportunity to have any questions answered.

Signature of Patient _____

Date _____

If patient is unable to sign, signature of person authorized to sign on patient's behalf:

Patient's Designee

Printed Name of Designee

Relationship to Patient

PLEASE ANSWER THE FOLLOWING QUESTIONS:

YES NO

Are you a caregiver or household contact to an infant under 6 months of age?		
Are you feeling well today?		
Do you smoke?		
Are you allergic to eggs (hives, trouble breathing)?		
Do you have a history of Guillain-Barre' syndrome?		
Have you had any bad reaction to a previous flu shot?		
Are you allergic to a mercury preservative called thimerosal?		
Are you allergic to one of the following components of the vaccine? Formaldehyde, Gelatin, Neomycin, Sucrose, Polymyxin B, Phenol		
Do you have a chronic illness or medical condition (heart disease, asthma or lung disease, cancer, diabetes, kidney disease, HIV positive, hepatitis, seizure disorder, long-term aspirin therapy)?		
Have you received a Zostavax ® (shingles) vaccine in the past 30 days?		
Have you ever had a pneumonia shot before? If so, when?		

Signature of RN completing assessment _____

Date _____

CLINIC USE ONLY

Vaccine Information Statements given as noted.

Immunization Given	Mfr: Lot # Sanofi Novartis	Injection Site & Route	Vaccine Adm. Signature/Title	PVT	ODH (GSK)	PVT Thimerosal-Free
Influenza		Left Deltoid IM				
Pneumonia		Right Deltoid IM				

Amount Paid _____ Receipt # _____ Receipt Date: _____

• Cash Visa MC Check # _____ Staff Initials: _____

Fee waived due to inability to pay _____

Supervisor Signature

Payment by 3rd Party (other than insurance) _____