NEMAHA VALLEY
Community Hospital & Seneca Family Practice
1600 Community Drive Seneca, KS 66538 Hospital 785-336-6181 SFP 785-336-6107

Influenza/Pneumococcal Immunization Consent Form

Patient Name: _____

DOB: _____ Age: _____

Primary Care Provider (circle one): Bartkoski Myers Snyder Stueve Other: _____

Current Insurance (circle one): BCBS Medicare KanCare Self-Pay Other: _____

I have been offered a copy of the Vaccine Information Statement(s) (VIS) about the influenza and/or pneumococcal vaccines and have read, had explained to me, and/or understand the information provided. I ask that the vaccine(s) below be given to me or to the person named above for whom I am authorized to make this request. I understand the risks and benefits of the influenza and/or pneumococcal vaccines and have had the opportunity to ask questions.

_____

Signature of Patient or Parent/Guardian **Date**

Immunization Screening Questionnaire (circle yes or no):

1. Is the patient to be vaccinated currently sick or experiencing a high fever? Yes No
2. Have you ever had a life threatening allergic reaction to any component of the flu or pneumonia vaccine, thimerosal (preservative found in contact lens solution), or latex? Yes No
3. Is the person receiving the vaccine pregnant or planning to be pregnant in the next month? Yes No
4. Does the person receiving the vaccine have a history of Guillain-Barre Syndrome or a persistent neurological illness? Yes No
5. Are you a smoker or have a chronic medical condition such as asthma, heart, liver, or lung disease, diabetes, and/or immunocompromised? Yes No
6. Have you ever had a severe allergic reaction to eggs, chickens, or chicken feathers? Yes No
7. Have you received any other vaccinations in the past 4 weeks? Yes No
8. For child 6mo-8yrs, have they received 2 or more doses of influenza vaccine in the same season since July 2010? Yes No

(If the answer is yes to #3 or #5, LAIV contraindicated, TIV recommended)

(Area below to be completed by Nurse)

Influenza Vaccine

Type (circle one): Adult High-Dose (≥65)

Brand (circle one): Fluzone Flulaval

Admin. Site (circle one): Left / Right Deltoid

Left / Right Vastus Lat.

Dosage: 0.5 ml

VIS Date: 8/15/19

Manufacturer: _____

Lot Number & Exp. Date: _____

Pneumonia Vaccine

Type (circle one): Prevnar13 Pneumovax23

Admin. Site (circle one): Left / Right Deltoid

Left / Right Vastus Lat.

Dosage: 0.5 ml

VIS Date: 10/30/19

Manufacturer: _____

Lot Number & Exp. Date: _____

_____

Signature and Title of Vaccine Administrator **Date/Time**