

**Influenza/Pneumococcal Immunization Consent Form**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Primary Care Provider (circle one): Bartkoski Hermesch Myers Snyder 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. I authorize payment of medical benefits to Seneca Family Practice RHC/NVCH and I understand that any remaining balance after insurance payments is my responsibility. I authorize release of medical information necessary to process this claim. I authorize consent of diagnostic treatment by SFP/NVCH staff and in the event that further testing needs to be done I may acquire charges from one of our contracted facilities.*

X \_\_\_\_\_

**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. Have you received any other vaccinations in the past 4 weeks? Yes No
6. **For child 6mo-8yrs**, have they received 2 or more doses of influenza vaccine in the same season since July 2010? Yes No

**(Area below to be completed by Nurse)**

**Influenza Vaccine**

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

Brand: Fluzone

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

Left / Right Vastus Lat.

Dosage (circle one): 0.5ml 0.7ml

VIS Date: 8/6/21

Manufacturer: Sanofi Pasteur

Lot Number & Exp. Date: \_\_\_\_\_

**Pneumonia Vaccine**

Type (circle one): Prevnar13 Prevnar20 Pneumovax23

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

Left / Right Vastus Lat.

Dosage: 0.5 ml

VIS Date: 5/12/23

Manufacturer (circle one): Pfizer Merck

Lot Number & Exp. Date: \_\_\_\_\_

**Signature and Title of Vaccine Administrator**

**Date/Time**