Influenza/Pneumococcal Immunization Consent Form

Please complete the questions below for yourself or the person receiving the vaccine.

☐ No  ☐ Yes Are you currently sick with a fever?
☐ No  ☐ Yes Have you ever had a life threatening allergy to any component (or part) of the flu or pneumonia vaccine?
  If yes, please describe: ____________________________
☐ No  ☐ Yes Have you ever developed Guillain-Barre Syndrome within 6 weeks of receiving flu vaccine?
☐ No  ☐ Yes Have you ever had a pneumonia shot?
☐ No  ☐ Yes Are you a smoker or have a chronic medical condition such as asthma, heart or lung disease?
  If yes, please describe: ____________________________
☐ No  ☐ Yes Have you ever had a severe life threatening allergy to eggs or egg products?
☐ No  ☐ Yes Are you currently pregnant?
☐ No  ☐ Yes Do you have a history of asthma or wheezing?
☐ No  ☐ Yes Are you a child or adolescent receiving long-term aspirin therapy?
☐ No  ☐ Yes Do you have a weakened immune system or have close contact with a person with an extremely weakened immune system who needs special care?
☐ No  ☐ Yes Have you received any other vaccinations within the last 4 weeks?
☐ No  ☐ Yes Have you taken an antiviral medication for the flu within the last 48 hours?

Influenza Consent
I have read, or had explained to me, the Vaccine Information Statement about influenza vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purposes. I have received a copy of the Patient Bill of Rights.

Pneumococcal Consent
I have read, or had explained to me, the Vaccine Information Statement about pneumococcal vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the pneumococcal vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purposes. I have received a copy of the Patient Bill of Rights.

Signature of Recipient (Parent or Guardian) ____________________________ Date __________

Area Below to Be Completed by Nurse

Influenza Vaccine
Administration Date ____________________________
Administration Site ☐ Left Arm ☐ Right Arm ☐ Nasal
☐ Left Thigh ☐ Right Thigh
Dosage ☐ 0.5 ml ☐ 0.25 ml ☐ LAIV
Manufacturer & Lot Number ____________________________
VIS Date ____________________________
Nurse Signature ____________________________
Next Immunization Due: ☐ Next Year ☐ In 4 Weeks ☐ Other __________

Pneumococcal Disease Vaccine
Administration Date ____________________________
Administration Site ☐ Left Arm ☐ Right Arm
☐ Left Thigh ☐ Right Thigh
Manufacturer & Lot Number ____________________________
VIS Date ____________________________
Nurse Signature ____________________________
Next Immunization Due: ☐ None Needed ☐ Other __________