

**TALBOT COUNTY HEALTH DEPARTMENT
ADULT FLU SHOT/ PNEUMOCOCCAL VACCINE CONSENT & ADMINISTRATION RECORD**

******* PLEASE PRINT INFORMATION ABOUT THE PERSON TO RECEIVE VACCINE *******

NAME: Last		First	Middle Initial	Birth Date (mm/dd/yy)	AGE:	
ADDRESS: Number & Street		(Apt #)	City	County	State	Zip
SEX: M / F	Daytime Phone #: ____-____-____					

******* PLEASE CIRCLE YES OR NO FOR EACH QUESTION. *******

QUESTIONS 1-4 DETERMINE IF VACCINE CAN BE GIVEN:		
1. Are you moderately or severely ill today WITH A FEVER?		YES NO
2. Have you ever had SEVERE/UNUSUAL REACTION after receiving any vaccine? Describe the reaction: _____		YES NO
3. Did the reaction involve PARALYSIS and/or occur within 6 wks after having flu vaccine?		YES NO
4. Have you ever had SEVERE ALLERGIC REACTION TO EGGS?		YES NO
QUESTIONS 5-10 DETERMINE IF SPECIAL PRECAUTIONS NEED TO BE TAKEN:		
5. Do you have diabetes or other metabolic disorder, or diseases of the lungs, heart, kidneys, liver, blood or nervous system? _____		YES NO
6. Do you have a weak immune system (from cancer, HIV or medicines containing steroids or for treating cancer)? _____		YES NO
7. Do you have any bleeding disorders or take aspirin or other anticoagulants every day?		YES NO
8. Are you pregnant at this time?		YES NO
9. List all your current medications. _____		
10. List all your allergies. _____		

******* PLEASE READ AND SIGN CONSENT ON THE LINE BELOW. *******

"I have read or had explained to me the information in the Vaccine Information Statement(s) (VIS) for influenza and/or pneumococcal vaccines. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and ask that they be given to me or to the person named above for whom I am authorized to make this request."
 "If not paying by cash today, I authorize the Talbot County Health Department to bill my insurance company (Medicare or Medical Assistance only) for services given to the person named above."
 "I have been given or offered a copy of the Notice of Privacy Policies (HIPAA) form."
 X _____ Relationship: _____ Today's Date: _____
 (Signature of person receiving or consenting to the vaccination)

FOR CLINIC USE ONLY BELOW THIS LINE

Vaccine given:	INFLUENZA	Pneumococcal (PPSV23)
Date of VIS:	8/07/2015	04/24/2015
Route of Administration: (Circle one)	IM: LA RA LL RL	IM: LA RA LL RL
Vaccine Manufacturer: (Circle one)	Sanofi Pasteur Novartis	Merck & Co., LLC
Vaccine Lot #/Expiration date:	Place label here.	Place label here
Signature & Title of Vaccine Administrator:	Today's Date:	