VACCINE ADMINISTRATION CONSENT FORM
ALACHUA COUNTY HEALTH DEPARTMENT

NAME _____
LAST FIRST MI

YOUR AGE TODAY _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____

RACE _____ SEX _____ COUNTY OF RESIDENCE _____ TELEPHONE ( ) _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

PLEASE ANSWER THE FOLLOWING QUESTIONS

DO YOU HAVE ANY ALLERGIES: _____

I AM REQUESTING A FLU SHOT: Yes ☐ No ☐ I AM REQUESTING A PNEUMONIA SHOT: Yes ☐ No ☐

"I have read or have had explained to me the information about influenza/pneumonia and influenza/pneumonia vaccine(s). I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza/pneumonia vaccine(s) and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request."

I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician or organization furnishing services or authorize such physicians or organization to submit a claim to Medicare for payment for me. I understand if I am a member of an HMO or Medicare is not my primary insurance; I will be personally responsible for any charges not covered by Medicare assignment. By my signature below, I acknowledge receipt of the Notice of Privacy Practices form and the Vaccine Information Statement.

Signature of Recipient/Guardian: _____ Date _____

If someone other than client, print name: _____ Relationship to client _____

*****STAFF USE ONLY *****

DATE VACCINATED: _____ CLINIC SITE _____

FLU VACCINE VIS 8/7/15 _____ PNEUMONIA VACCINE VIS _____

MFG/LOT # _____ MFG/LOT# _____

SITE/ROUTE LDT RDT IM IN _____ SITE/ROUTE _____ LDT RDT IM _____

NURSE _____ NURSE _____

Client Label

Last Name _____

First Name _____

Date Of Birth _____

Date

Appt Time

Work Up

IN

Out

Cashier Only Cashier Initials _____

Copay Paid Y N $ _____ _____

SFS Paid Y N $ _____ _____

Prev Bal Paid Y N $ _____ _____

No Payment Y N $ _____

Lab Orders

Revised 9/16/16rlh