



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 (CIRCLE ONE): **FLU SHOT** **FLU MIST**

I AM REQUESTING A PNEUMONIA SHOT: **YES** **NO**

	YES	NO	DON'T KNOW
1. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist®) in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is the person to be vaccinated younger than age 2 years or older than age 49 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider ever told you that he or she had wheezing or asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Is the person to be vaccinated receiving antiviral medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is the person to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is the person to be vaccinated pregnant or could she become pregnant within the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the person to be vaccinated ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective environment (such as in a hospital room with reverse air flow)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

"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 that 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 physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that 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 Rights.

SIGNATURE OF RECIPIENT/GUARDIAN: _____ DATE: _____

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

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

DATE VACCINATED: _____	CLINIC SITE _____
FLU VACCINE VIS _____	PNEUMONIA VACCINE VIS _____
MFG/LOT # _____	MFG/LOT# _____
SITE/ROUTE LDT RDT IM IN _____	SITE/ROUTE LDT RDT IM _____
NURSE _____	NURSE _____