TOMPKINS COUNTY HEALTH DEPARTMENT
Your Partner for a Healthy Community

FLU/Pneumo Vaccination Consent Form For Adults

Clinic Site: _____ Clinic Date: ____/____/2011 Date of birth: ___/___/_____

First Name: _____ Last Name: _____ Age: _____

Address: _____ City:_____State: ____ ZIP:_____ Township:_____

Phone #: _____ Cell #: _____ M or F (circle one)

Doctor's name: _____ City:_____ State: _____

_____ I acknowledge receipt of the Tompkins County Health Dept. Notice of Privacy Practices.
(initials)

_____ I understand if my insurance does not reimburse the Tompkins County Health Dept. for my
(initials) vaccination (s) I will be responsible for payment.

Are you allergic to eggs? ( ) YES ( ) NO Are you sick with a fever today? ( ) YES ( ) NO
Ever had a serious reaction to a flu shot? ( ) YES ( ) NO
Ever had Guillain Barre syndrome? ( ) YES ( ) NO

Influenza Consent: I have read, or had explained to me, the information sheet about **flu** 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 **flu** 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 an insurance claim or for public health purpose.

_____ _____
Signature of recipient or guardian **Date**

Flu Vaccine Dose: **0.5 cc** Route: **IM** Site: ( ) Left deltoid ( ) Right deltoid

Manufacturer: **Sanofi Pasteur Lot #: _____** VIS date **7/26/11** ( ) Reviewed side effects with recipient/guardian

Nurse signature _____

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Are you 50 years of age or older? ( ) Yes ( ) No Smoker? ( ) Yes ( ) No Asthma? ( ) Yes ( ) No
Chronic medical condition i.e. heart or lung disease, diabetes ( ) Yes ( ) No
Have you had pneumo vaccine before? ( ) Yes ( ) No Has it been ≥ 5 years ago? ( ) Yes ( ) No
Allergy to previous pneumo vaccine? ( ) Yes ( ) No

Pneumococcal Consent: I have read, or had explained to me, the information sheet 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 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 an insurance claim or for public health purpose.

_____ _____
Signature of recipient or parent/guardian **Date**

Pneumococcal Polysaccharide Vaccine Dose: **0.5cc** Route : **IM** Site: ( ) Left deltoid ( ) Right deltoid
Manufacturer: **Merck Lot # 843AA** VIS date **10/6/09** ( ) Reviewed side effects with recipient/guardian

Nurse signature _____ 2011 version

For Office Use Only: Insurance Co. _____ ID# _____ effective date _____

Co-pay_____/ Co-insurance_____/ NONE cash pay $ _____ Check # _____

□ Bill employer: _____ □ County employee – Dept: _____