

Coastal Health District 9-1

NAME _____
 (LAST) (FIRST) (MIDDLE)

BIRTHDATE _____ AGE _____ RACE _____ SEX _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

WELLCARE # _____ MEDICAID # _____

PEACHSTATE # _____ PEACHCARE # _____

AMERIGROUP # _____ MEDICARE # _____

COPY OF CARD ATTACHED? Yes ___ No ___ IF NO, CARD # _____

If over 65, have you ever had a Pneumonia shot? NO _____ YES _____ If yes, what year? _____

I have been given a copy and have read, or have had explained to me, the information in the Vaccine Information Pamphlet(s) or the Important Information Statement(s) for the vaccines checked. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines requested and ask that the vaccines checked be given to me or the person named for whom I am authorized to make this request.

VACCINE	MFG/LOT #	DOSE/ ROUTE	SITE (circle)		FORM/ DATE	DATE GIVEN	NURSE SIGNATURE
FLU		0.5 ML/IM	LD	RD	Influenza		
PNU		0.5 ML/IM	LD	RD	Pneumoccal		

 Signature of Patient/Guardian

 Date

FEES: FLU _____ PNEUMONIA _____

PAYMENT: AMOUNT DUE _____	AMOUNT PAID _____	CASH _____	CHECK # _____
MEDICARE # _____ (COPY ATTACHED)	MEDICAID # _____ (COPY ATTACHED)		

VACCINE INFORMATION AND CONSENT FORM

Answer the following about the person receiving the immunizations:

Questions	Yes	No	Don't know
1. Is this person sick today?			
2. Does this person have allergies to medications, eggs, gelatin, yeast, Latex, any vaccine, or any vaccine component?			
3. Has this person ever had a serious reaction after receiving a vaccination?			
4. Do you, any person who lives with you, or any person you take care of take cortisone, prednisone, other steroids, anticancer drugs, or x-ray treatments?			
5. Do you, any person who lives with you, or any person you take care of have cancer, leukemia, AIDS, or any other immune system problem?			
6. During the past year has this person received a transfusion of blood or plasma, or been given a medicine called immune globulin?			
7. For women: Is it possible that you are or may become pregnant in the next four weeks?			
8. For children: Has the child had a seizure or neurological problem?			
9. Has this person received any vaccinations in the past four weeks?			

I understand the information in the Vaccine Information Pamphlet(s) and/or the Important Information Statement(s) for the vaccine(s) indicated. All of my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccines requested and ask that they be given to me or to the person named for whom I am authorized to make this request.

_____ **Date of Immunization**

_____ **Patient/Guardian Signature**