

Client # \_\_\_\_\_

Coastal Health District  
 Chatham County Health Department  
 1395 Eisenhower Drive  
 Savannah Georgia 31406

DATE \_\_\_\_\_

IT IS RECOMMENDED THAT ANYONE  
 RECEIVING A VACCINE REMAIN FOR 30 MINUTES  
 AFTER GETTING THE SHOT BEFORE LEAVING!

NAME \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

BIRTHDATE: \_\_\_\_\_ AGE \_\_\_\_\_ RACE \_\_\_\_\_ SEX \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

MEDICARE / MEDICAID / (circle one) Effective date \_\_\_\_\_

COPY OF CARD ATTACHED? Y / N 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#	Dsg/Rte	Site	Form#	Date	Nurse	Signature	Date
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FLU	U3199AA-CP	0.5ML/IM			06/30/2010			
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Amt. Due _____	Amt. Paid _____
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