

PNEUMOCOCCAL VACCINE CONSENT/ADMINISTRATION RECORD



Name:	Birth Date:	Sex: M F
Address:		City:
State:	Zip:	Phone:
PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "YES" to any question(s), additional information may be needed before receiving the vaccination.	YES	NO
Has the person receiving the vaccine had a Pneumonia shot in the past?		
Is the person being vaccinated sick today?		
Is the person being vaccinated allergic to Thimerosal (a mercury derivative found in contact lens solution and Merthiolate)?		
Does the person being vaccinated have a latex allergy?		
For Women: Are you pregnant or is there a chance you could become pregnant?		
Is the person being vaccinated currently undergoing chemotherapy or radiation therapy, or are having these therapies within the next two weeks?		

PLACE A CHECK OR INITIAL BESIDE EACH OF THE FOLLOWING STATEMENTS:

- I have received a copy of the pneumococcal vaccine information sheet.
- To the best of my knowledge, I understand the benefits and/or risks of the pneumococcal vaccine.
- I have had a chance to ask questions about the vaccine that were answered to my satisfaction.
- I request to receive the pneumococcal vaccine, or request the vaccine be given to the above-named individual for whom I am authorized by law to make said request.
- I have received and/or have had explained to me the Notice of Privacy Practices Summary, which explains the policies concerning my personal health information.

I authorize _____ to release to the below-named insurance company any medical or other information required to process a claim for benefits. I understand that _____ will accept assignment of my claim and my signature below authorizes said intermediary to pay benefits on my behalf, directly to _____. I understand that any information so released will be treated as confidential by _____, in accordance with _____ HIPAA policies.

Signature of person receiving vaccine or person authorized to make the request (parent/guardian):

X _____ **Date:** _____

CHECK THE BOX BY YOUR PRIMARY INSURANCE COVERAGE. WRITE DOWN INSURANCE NUMBERS AND HAVE INSURANCE CARD OUT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES INCURRED IF MEDICARE/PRIMARY INSURANCE COVERAGE DOES NOT PAY.

<input type="checkbox"/> Medicare	<input type="checkbox"/> Medigold
<input type="checkbox"/> Medicaid (Billing Number)	<input type="checkbox"/> Other

TO BE COMPLETED BY HEALTHCARE PERSONNEL:

Healthcare Provider:	Injection Site: LD RD	Vaccine Manufacturer & Lot # _____ Expiration Date:
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