VACCINE DOCUMENTATION / CONSENT FORM

I have been offered or provided, whether accepted or not, a copy of the AVaccine Information Statement(s)@ checked below. I have read, or have had explained to me, the information in the AVaccine Information Statement(s)@. My questions have been answered satisfactorily, and I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request.

❻ Influenza-inactivated (shot)
❻ Influenza-live (nasal spray)
❻ Pneumococcal (PPV23)

❻ I hereby authorize the release of my immunization records to appropriate healthcare providers.
❻ **Medicare Eligible Clients**: I give permission to the Hodgeman County Health Department to bill Medicare for the vaccine(s) checked above.

Signature of Patient or Parent/Guardian

Date

Patient Information					
Patient=s Last Name Patient=s First Name	Phone #	Age	Birth Date	Gender M F
Street Address / **PO Box #**	City	County	State	Zip
Primary Care Physician:					

(Flu Shot 1-4) (Complete all for nasal spray)

Immunization Screening Questionnaire	
1. Do you have a serious allergy to eggs?	___yes ___ no
2. Have you had a serious allergic reaction or any other problem after getting the influenza vaccine?	___yes ___ no
3. Were you ever paralyzed by Guillain-Barré Syndrome?	___yes ___ no
4. Are you currently sick?	___yes ___ no
5. Is the person to be vaccinated younger than 2 years or older than age 49 years?	___yes ___ no
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?	___yes ___ no
7. Is the person to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	___yes ___ no
8. Is the person to be vaccinated pregnant or could she become pregnant within the next month?	___yes ___ no
9. Has the person to be vaccinated received any other vaccinations in the last 4 weeks?	___yes ___ no
10. 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?	___yes ___ no
11. 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?	___yes ___ no
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 air flow)?	___yes ___ no

PATIENT ELIGIBILITY

____HW (19 or 21) ____Underinsured ____Underserved ____No Health insurance ____Native AM/Alaska Native ___Fully Insured ____Medicare

Name, as it appears on Medicare Card ________________________________

Medicare Number ________________________________

(Circle the appropriate vaccine, dose, extremity, site, route, and enter the VIS date, manufacturer, lot #, and expiration date)

For Clinical Use Only						
VACCINE	EXT	SITE	ROUTE	VIS DATE	MANUFACTURER LOT #	EXP DATE
Influenza, Inactivated	0.1ml 0.25ml 0.5ml RT LT	Deltoid Vastus Lat Upper Arm	IM Intradermal	07-26-11		
Influenza, LAIV			0.1 ml Intranasal each nostril	07-26-11		
Pneumococcal	RT LT	Deltoid	IM	10-6-09		

________________________________ ________________

Signature and Title of Vaccine Administrator

Date

(Circle the appropriate vaccine, dose, extremity, site, route, and enter the VIS date, manufacturer, lot #, and expiration date)

For Clinical Use Only						
VACCINE	EXT	SITE	ROUTE	VIS DATE	MANUFACTURER LOT #	EXP DATE
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Influenza, LAIV			0.1 ml Intranasal Each nostril	07-26-11		

________________________________ ________________

Signature and Title of Vaccine Administrator

Date

Date **Progress Notes** ________________________________

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Provider Information

Hodgeman County Health Department
c/o Courthouse, 500 Main
PO Box 86
Jetmore, KS 67854
(620) 357-8736