

BETHLEHEM HEALTH BUREAU
Seasonal Influenza/Pneumonia Vaccination Consent Form

Name: _____ Date of Birth: _____ Sex: M ___ F ___

Address: _____ Telephone: _____ Zip Code: _____

Please circle YES or NO to the questions below:

- | | | |
|-------------------------------------------------------------------------------|-----|----|
| 1. Does the patient have a severe allergy to eggs? | Yes | No |
| 2. Has the patient ever had a severe reaction to an influenza vaccine? | Yes | No |
| 3. Has the patient ever had Guillian-Barre syndrome (immune system disorder)? | Yes | No |
| 4. Does the patient have any other allergies? _____ | Yes | No |
| 5. Does the patient have medical insurance that covers vaccinations? | Yes | No |

INSURANCE None/Private/Public

Carrier _____

Policy ID. Number _____ Group Number _____

Employer _____

Insured Name (IF NOT PATIENT) _____

_____/_____/_____
DOB

_____/_____/_____
SSN

I have received and read the Centers for Disease Control and Prevention Vaccine Information Sheet dated 8/7/2015. I have no further questions at this time. I request and voluntarily consent that the seasonal influenza vaccine be given to person named above **of whom I am or am the parent or legal guardian.**

Signature: _____ Date: _____

OFFICE USE ONLY

Influenza Vaccine Given Lot Number: _____ Exp date: _____ Injection Site: L / R

Dosage Volume: .25ml .5ml

Signature of vaccine administrator

Date

Pneumonia Vaccine Given Lot Number: _____ Exp date: _____ Injection Site: L / R

Prevnar/Pneumovax

I have received and read the Centers for Disease Control and Prevention Vaccine Information Sheets dated 11/5/2015 or 4/24/2015. I request and voluntarily consent that the pneumonia vaccine be given to person named above.

Signature: _____ Date: _____

Signature of vaccine administrator

Date