

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 Gullian-Barre syndrome? | Yes | No |
| 4. Does the patient have any other allergies? _____ | Yes | No |
| 5. Does the patient have asthma or recurrent or active wheezing? | Yes | No |
| 6. Has the patient received either the MMR, Varicella, Yellow Fever or FluMist
Vaccination in the past 30 days? Date: _____ | Yes | No |
| 7. If applicable, is the patient pregnant or nursing? | Yes | No N/A |
| 8. Does the patient have close contact with anyone who has a severely
weakened immune system that must be in a protective environment? | Yes | No |
| 9. 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 Sheets 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: _____	Injection Site: <u>L / R</u>
Dosage Volume: .25ml .5ml Intranasal		
_____ Signature of vaccine administrator	_____ Date	
Pneumonia Vaccine Given	Lot Number: _____	Injection Site: <u>L / R</u>
_____ Signature of vaccine administrator	_____ Date	