NYS Veterans Home at Batavia Staff
Influenza/Pneumococcal Immunization Consent From

Name (Please Print) Date of Birth Sex County of Residence

_____

Address City State Zip

_____

Phone For Persons Inder 19 Years Old, Mother's Maiden Name

_____

Medicare Claim Number Doctor's Name

_____

Health Insurance Provider Doctor's Address

_____

Insurance Policy Number Clinic Office Site Where Vaccine Administered

_____ New York State Veterans Home at Batavia _____

Please complete the questions below.

Are you currently sick with a fever? Yes No

Have you ever had a life threatening allergy to any component (or Part) of the flu or pneumonia vaccine? Yes No

If yes, please describe: _____

Have you ever developed Guillain-Barre-Syndrome within 6 weeks of receiving flu vaccine? Yes No

Have you ever had a pneumonia shot? Yes No

Are you a smoker or have a chronic medical condition such as asthma, heart, or lung disease? Yes No

If yes, please describe: _____

Have you ever has a severe life threatening allergy to eggs or egg products? Yes No

Are you currently pregnant? Yes No

Do you have a history of asthma or wheezing? Yes No

Do you have a weakened immune system or have close contact with a person with an extremely weakened immune system who needs special care? Yes No

Have you received any other vaccinations within the last 4 weeks? Yes No

Have you taken any antiviral medication for the flu within the last 48 hours? Yes No

I have read, or had explained to me, the Vaccine Information Statement about **influenza** vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the **influenza** vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose. I have received a copy of the Patient Bill of Rights.

I decline to receive the influenza vaccine ☐ I consent to receive the influenza vaccine ☐

Signature _____ Date _____

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Influenza/Pneumococcal Immunization Consent From

I have read, or had explained to me, the Vaccine Information Statement about **pneumococcal** vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the **Pneumococcal** vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose. I have received a copy of the Patient Bill of Rights.

I decline to receive the pneumococcal vaccine ☐ I consent to receive the pneumococcal vaccine ☐

Signature _____ Date _____

Area Below to be Completed by Nurse

Influenza Vaccine

Administration Date _____

Administration Site ☐ Left Arm ☐ Right Arm

Dosage ☐ 0.5 ml ☐ 0.25 ml ☐ LAIV

Manufacturer & Lot # _____

VIS Date _____

Nurse Signature _____

Next Immunization Due: ☐ Next Year ☐ 4 Weeks ☐ Other

Pneumococcal disease Vaccine

Administration Date _____

Administration Site ☐ Left Arm ☐ Right Arm

Manufacturer & Lot # _____

VIS Date _____

Nurse Signature _____

Next Immunization Due: ☐ None Needed ☐ Other