INFLUENZA HIGH DOSE VACCINE RECORD & CONSENT

Adult (65 years and above)

"I have read or have had explained to me the information in the Vaccine Information Statement (VIS) about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request."

Information about person to receive vaccine **PLEASE PRINT (Medicare/RR clients please print name as it appears on the card)**

NAME:_____ **BIRTHDATE**_____ **AGE**_____
Last First Initial

ADDRESS:_____ HOME PHONE #: _____
Street

_____
City State Zip Code

Information about person to receive vaccine. **PLEASE CIRCLE YES OR NO**

1. Are you feeling well today?	YES	NO
2. Have you ever had a serious reaction to a flu shot before (e.g., hives, breathing problems)? If yes, briefly describe _____	YES	NO
3. Are you allergic to eggs?	YES	NO
4. Are you allergic to latex, gelatin or thimerosal?	YES	NO
5. Have you ever been paralyzed?	YES	NO
If yes, ever diagnosed with Guillain-Barré Syndrome?	YES	NO
6. Have you ever received the Pneumonia (Pneumococcal) vaccine? If yes, when? _____	YES	NO
7. Has it been more than 10 yrs. since your last Td (Tetanus-diphtheria booster)?	YES	NO

Please Circle*: (For Statistical Purposes Only)*

A) **Sex:** Male Female
B) **Race:** White African American Asian/Pacific Islander Asian Indian Other_____
C) **Ethnicity:** Non Hispanic Hispanic Unknown

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

X_____ DATE: _____
SIGNATURE

COMPLETE OTHER SIDE

FOR CLINIC/OFFICE USE ONLY

Clinic Site: _____

Date Vaccine Administered: _____

Vaccine Manufacturer: Sanofi Pasteur

Lot Number: _____ **Dosage: 0.5 cc** **Exp. Date:**

Site of Injection: **RIGHT Deltoid, IM** **LEFT Deltoid, IM**

Signature of Vaccine Administrator: _____ **VIS: 7/2/12**

MEDICARE/RAILROAD CLIENTS ONLY

Please present ALL medical cards to the receptionist for copying. Thank you.

Please read and sign below:

If Medicare denies payment for my claim for the Influenza Vaccine for any reason, I understand that I am financially responsible for the cost of the immunization. I understand that the Chester County Health Department will bill me the cost of the vaccine plus administrative fees.

Signature _____ Date_____

For office use only:

Medicare/High Dose_____ **RR_____**

Cash _____ **Check_____**