

2015-2016 Influenza and/or Pneumococcal Vaccine Patient Form

Wayne County Health Dept.

217 Kenova Avenue
Wayne, WV 25570
(304)272-6761

Personal Information (Please Print Clearly): Date _____

Name: _____

Birth Date: _____ **Age:** _____ **Sex:** _____ **Telephone:** _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Medicare Recipient # _____ **Railroad #** _____ **Humana#** _____

Have you ever had : The Following

Serious reaction to the vaccine? Yes No

Serious allergic reaction to eggs? Yes No

Guillain-Barre syndrome? Yes No

Your flu shot already this season? Yes No

I have been given a copy and have read or have had explained to me the information sheet about Influenza Virus Vaccine 2015-2016 dated 8/19/14 or Live, Intranasal Influenza Vaccine dated 8/19/14 and/or Pneumococcal Vaccine Dated 04/24/2015. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that this be given to me or to the person named below for whom I am authorized to make this request. I acknowledge that I have been offered a copy of the *Notice of Privacy Practices* for the Wayne County Health Department. This notice explains how my protected health information is used and/or disclosed for the purposes of treatment, payment, and health care operations. ***For Medicare Recipients: I authorize the release of my medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.***

Signature: _____

Area Below is for Staff Use Only:

Risk Assessment:

- 65 years of age or older.
- 50-64 years of age.
- Resident of nursing home or chronic care facility.
- Chronic heart or lung disease, diabetes, kidney disease, anemia, or other blood disorders(not including high blood pressure).
- Compromised immunity.
- Children (6months-18years) on aspirin long-term.
- Pregnant or will be during the Flu Season.
- Healthy Children (6months-18 years).
- Household Contacts or Caretakers of anyone in the above groups or of a child less than 6 months old.
- Health Care Providers who provide direct care.
- Last Pneumonia shot date _____

No Contraindications were identified

Influenza vaccine administered:

Manufacturer : _____ Lot # _____ Exp: _____
Location: R or L Deltoid

Flu mist administered:

Manufacturer _____ Lot # _____ Exp : _____

Pneumococcal vaccine administered.

Manufacturer _____ Lot # _____ Exp. _____
Location: R or L Deltoid

Administered By: _____

