Pneumovax23 Vaccine Consent Form

I have read or had explained to me the information about pneumovax23 and pneumovax23 vaccine. I have had a chance to have questions answered to my satisfaction, and request the vaccine be administered to me or the person named below for whom I am legally authorized to make this request. I understand the health department is already authorized to use the information gained during treatment to request payment upon day of service or bill Medicaid, Medicare or Insurance Carrier for reimbursement for services. I also acknowledge that I have had an opportunity to receive/read a copy of the "Joint Notice of Privacy Practices" dated 09/23/13 as well as the most current Vaccine Information Statement (VIS) from the health department.

PLEASE PRINT NAME EXACTLY AS ON IDENTIFICATION

NAME (Last)	(First)	(M.I.)
ADDRESS	CITY	

STATE	ZIP	PHONE #	BIRTHDATE	AGE

SIGNATURE	DATE

********For Clinic Use Only********

Date:_____ **Clinic Location:_____**

Do any of the following apply to person being vaccinated?

- ☐ I am feeling well
- ☐ Have you ever received a dose of Pneumococcal vaccine before?
- ☐ Severe allergic reaction to vaccine component or following prior dose of vaccine
- ☐ Diabetic?

Vaccine Manufacturer: _____ **Lot #: _____ VIS 4/24/15**

Site:
Deltoid R or L

RN / Student Nurse:_____

PAYMENT:
- ☐ Cash
- ☐ Check # _____
- ☐ Credit
- ☐ Insurance _____
- ☐ Medicaid # _____
- ☐ Medicare # _____