Coles County Health Department
Pneumococcal Vaccine Administration Record

I have read or had explained to me the information about pneumonia and pneumococcal vaccine. I have had a chance to have questions answered to my satisfaction. I understand the benefits and risks of pneumococcal vaccine and request the vaccine be administered to me or the person named below for whom I am legally authorized to make this request.

PLEASE PRINT

Last Name:	First Name:	Middle Initial:

Street Address:	City:

State:	Zip Code:	Phone #:	Birthdate:	Age:

Do any of the following apply to person being vaccinated? Please check all that apply.

□ I am feeling well.
□ Pregnant?
□ Have you ever received a dose of pneumococcal vaccine before?
□ Severe allergic reaction to vaccine component or following prior dose of vaccine
□ Diabetes?

I do hereby consent to allow the health department and its designated employees to enroll and provide services through the programs offered by the department. I understand the nature and consequences of any procedures to be performed will be explained to me. I understand the health department is already authorized to use the information gained during treatment to bill me, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services. I also acknowledge that I have had an opportunity to receive a copy of the "Joint Notice of Privacy Practices" dated 4/14/2003 as well as the most current Vaccine Information Statement (VIS) from the health department.

Signature:	Date:

For Clinic Use Only

Date:_____________ **Clinic Location:**____

Vaccine Manufacturer: **Merck** **Lot #:**_______________________

VIS: 04/16/09

Injection Site:

□ Deltoid R or L
□ Vastus Lateralis R or L

RN/LPN/Student Nurse:____________________

□ **Medicare #** _____________________________
□ **Medicaid #** _____________________________
□ **Paid Cash/Check**
□ **Credit/Debit MC or Visa**

08/09