

# Flu / Pneumonia Consent Form

I have read or have had explained to me the information on the VIS form. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the pneumococcal and/or influenza vaccine and request that the vaccine be given to me or to the person named below for whom I am authorized to make this request. If I have Medicare or Medicaid (Jasper County Health Department can only bill Medicaid for this service for individuals 18 years of age and younger), I authorize billing for this injection. I understand that if Medicare or Medicaid denies to pay for this service, I am responsible for payment.

Date of Immunization: \_\_\_\_\_ Flu \_\_\_\_\_ Pneumonia \_\_\_\_\_

**(Must be exactly as it appears on your Medicaid or Medicare card)**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ If child - Age \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Phone Number: \_\_\_\_\_

**Choose Method of Payment:**

Medicare Number: \_\_\_\_\_ Medicaid Recipient Number: \_\_\_\_\_ Cash/Check \_\_\_\_\_

Signature: \_\_\_\_\_

---

**\* Must be completed the day of the vaccination:**

1. Are you feeling well today? Yes \_\_\_ No \_\_\_
2. Are you allergic to chicken/egg products? Yes \_\_\_ No \_\_\_
3. Have you ever had Guillain-Barre Syndrome? Yes \_\_\_ No \_\_\_
4. Have you ever had a reaction to a flu shot? Yes \_\_\_ No \_\_\_
5. If you are female, are you pregnant? Yes \_\_\_ No \_\_\_ N/A \_\_\_

\*\*\*\*\*

**For office use only:** Business to bill to: \_\_\_\_\_  
Nurse \_\_\_\_\_ L R Deltoid VIS \_\_\_\_\_

**Flu:** Lot # \_\_\_\_\_  
Expiration Date: \_\_\_\_\_  
Manufacturer: Aventis

**Pneumonia:** Lot: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_  
Manufacturer: \_\_\_\_\_