

**2009-2010 Influenza and/or Pneumococcal Vaccine Patient Form**  
**Wayne County Health Dept.**  
 590 Railroad Avenue  
 Wayne, WV 25570  
 (304)272-6761

**Personal Information (Please Print Clearly):**      Date \_\_\_\_\_

**Name:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Medicare Recipient #** \_\_\_\_\_  **Railroad**  **Advantra**  **Humana**  **None**

| Have you ever had :                       | Yes                      | or | No                       |
|---|--------------------------|----|--------------------------|
| <u>Serious</u> reaction to the vaccine?   | <input type="checkbox"/> |    | <input type="checkbox"/> |
| <u>Serious</u> allergic reaction to eggs? | <input type="checkbox"/> |    | <input type="checkbox"/> |
| Guillain-Barre syndrome?                  | <input type="checkbox"/> |    | <input type="checkbox"/> |
| Your flu shot already this season?        | <input type="checkbox"/> |    | <input type="checkbox"/> |

I have been given a copy and have read or have had explained to me the information sheet about Influenza Virus Vaccine 2009-2010 dated 8/11/09 or Live, Intranasal Influenza Vaccine dated 8/11/09 and/or Pneumococcal Vaccine Dated 4/16/09. 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  

Pneumococcal vaccine administered.  
 Manufacturer \_\_\_\_\_ Lot # \_\_\_\_\_ Exp. \_\_\_\_\_  
 Location:   R  or  L  Deltoid  

Adm. by Signature \_\_\_\_\_

