McLaren Medical Group

PNEUMOCOCCAL VACCINE CONSENT/ADMINISTRATION

Last Name: _____ First Name: _____ Sex: ❑ Male ❑ Female

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Physician: _____

Date of Birth: _____ Medicare Number (if applicable): _____

Please complete the following questions to appropriately evaluate any contradiction to receiving the pneumococcal vaccine:

1. Are you 65 years of age or older? ❑ Yes ❑ No
2. Have you received the vaccine before? ❑ Yes, Date: _____ / _____ / _____ ❑ No
3. Do you have a chronic illness? ❑ Yes ❑ No

   (If yes, please specify): _____

   _____
4. Do you have Hodgkin's Disease? ❑ Yes ❑ No
5. Are you allergic to any medications or food? ❑ Yes ❑ No
6. Are you pregnant? ❑ Yes ❑ No
7. Are you a nursing mother? ❑ Yes ❑ No
8. Do you have an infection? ❑ Yes ❑ No

Having received the pneumococcal vaccine information (dated 10-6-09) and informed consent, I hereby agree to release and hold McLaren Ambulatory Care Center/McLaren Occupational Health/Convenient/Prompt Care Center, its employees, agents and representative harmless from further responsibility with regard to my receiving the injection.

I have read the above information and have had the opportunity to ask questions. I understand the benefits and risks of the pneumococcal vaccine as described. I request that the pneumococcal vaccine be given to me or to the person named for whom I am authorized to sign.

Signature of Patient or Authorized Representative (Relationship): _____

Date: _____ / _____ / _____

FOR CLINIC USE ONLY:

Site of injection: ❑ Right Deltoid ❑ Left Deltoid

Manufacturer: _____ Lot number: _____ Expiration date: _____ / _____ / _____

Given by: _____ Date: _____ / _____ / _____