McLaren Business Products

McLaren Print System Order

Order No: 6199
Order Date: 2014-10-01
User: Deanna Parinello
Phone: 586-627-2727

Ship Location: BRIDGEVIEW/ ATTN: DEANN
39833 BRIDGEVIEW STREET
HARRISON TOWNSHIP, MI 48045
Forms
Quantity: 100
Paragon Dept No: 71200
Dept Name: BRIDGEVIEW FAMILY MEDICINE & URGENT CARE
Company Number: 810

Order Total Price: 11.70

Form Number: MM-152
Form Description: Pneumococcal Vaccine Consent / Administration
Revision Date: 9/2012
Print: 1 sided black and white
Paper: 2 Part (White, Yellow)
Size: 8.5 x 11
Fold:
Finish:
Drill: None

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: ____/____/____

PNEUMOCOCCAL VACCINE CONSENT/ ADMINISTRATION

ORIGINAL - Center CANARY - Patient