

McLaren Print System Order

Order No: 9714 Reprint Previous Order No: 5589
 Order Date: 2015-03-11
 User: Shelby Coolbaugh
 Phone: 517-975-3803

Ship Location: MGL Internal Medicine
 6465 Millennium Drive Suite 100
 Lansing, MI 48917

Forms

Quantity: 100
 Paragon Dept No: 67200
 Dept Name: MGL Internal Medicine
 Company Number: 810

Order Total Price: 11.70

Item Number: MM-152
 Item Description: Pneumococcal Vaccine Consent / Administration
 Revision Date: 2/2015
 Print: 1 sided black and white
 Paper: 2 Part (White, Yellow)
 Size: 8.5 x 11
 Fold:
 Finish: None
 Drill: None
 Misc Info:

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 contraindication 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 polysaccharide (PPSV) vaccine information (dated 10-6-08)
 the pneumococcal conjugate (PCV13) vaccine information (dated 02/2013)

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
 03/10/15 ORIGINAL - Center CAPABILITY - Patient