NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Immunization

Influenza/Pneumococcal Immunization Consent Form

Name (Please Print) | Date of Birth | Sex | County of Residence

Address | City | State | ZIP

Phone | For Persons Under 19 Years Old, Mother's Maiden Name

Medicare Claim Number | Doctor's Name

Health Insurance Provider | Doctor's Address

Policy Number | Clinic/Office Site Where Vaccine Administered | NYSIIS Permission ≥ 19 Years Old ☐ No ☐ Yes

☐ No ☐ Yes Are you (your child) currently sick with a fever?
☐ No ☐ Yes Do you (your child) have a severe allergy to eggs, latex or an ingredient of the flu or pneumococcal vaccine?
If yes, which? _____
☐ No ☐ Yes Have you (your child) ever had Guillain Barré syndrome?
☐ No ☐ Yes Is this your (your child's) first time getting the flu vaccine?
☐ No ☐ Yes Have you (your child) had any vaccine within the last 28 days?
If yes, which vaccine? _____ Date? _____
☐ No ☐ Yes Have you ever had a pneumonia shot?
If yes, when? _____
☐ No ☐ Yes Are you (your child) a smoker or do you (your child) have a chronic medical condition such as asthma, heart or lung disease?
If yes, please indicate "smoker" or name of chronic disease. _____
☐ No ☐ Yes Are you (your child) pregnant?
☐ No ☐ Yes For children 2-4 years: Has your child had asthma or wheezing episodes in the last year?
☐ No ☐ Yes Have you (your child) taken antiviral medication to prevent the flu within the last 48 hours?
☐ No ☐ Yes Is your child or adolescent receiving long-term aspirin treatment?
☐ No ☐ Yes Are you (your child) currently receiving radiation, chemotherapy, or immunosuppressive therapy?
☐ No ☐ Yes Do you (your child) have close contact with anyone with a severely weakened immune system?

Influenza Consent

I have read, or had explained to me, the Vaccine Information Statement about **influenza** vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the **influenza** vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose. I have received a copy of the Patient Bill of Rights.

Signature of Recipient (Parent or Guardian) | Date

Pneumococcal Consent

I have read, or had explained to me, the Vaccine Information Statement about **pneumococcal** vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the **pneumococcal** vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose. I have received a copy of the Patient Bill of Rights.

Signature of Recipient (Parent or Guardian) | Date

Area Below to Be Completed by Nurse

Influenza Vaccine

Administration Date _____

Administration Site ☐ Left Arm ☐ Right Arm ☐ Nasal ☐ Left Thigh ☐ Right Thigh

Dosage ☐ 0.5 ml ☐ 0.25 ml ☐ LAIV

Manufacturer & Lot Number _____

VIS Date _____

Nurse Signature _____

Next Immunization Due: ☐ Next Year ☐ In 4 Weeks ☐ Other _____

Pneumococcal Disease Vaccine

Administration Date _____

Administration Site ☐ Left Arm ☐ Right Arm ☐ Left Thigh ☐ Right Thigh

Manufacturer & Lot Number _____

VIS Date _____

Nurse Signature _____

Next Immunization Due: ☐ None Needed ☐ Other _____