CLINIC ID / SITE

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Wayne County Department of Public Health
Immunization Consent Form

LAST NAME | FIRST NAME | MI | DATE

DATE OF BIRTH MM/DD/YY | AGE | SEX (circle) M F | DAYTIME PHONE ( )

STREET ADDRESS | CITY | ZIP

SOCIAL SECURITY NUMBER | MEDICARE NUMBER | MEDICAID NUMBER

MARK YES OR NO FOR EACH QUESTION

Question	Yes	No
Do you know of any known sensitivity to any components of the influenza virus vaccine?	☐ Yes	☐ No
Do you have sensitivity to latex?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Are you allergic to chicken eggs or egg products?	☐ Yes	☐ No
Are you allergic to Thimerosal (cleaning products or contact lens solution)?	☐ Yes	☐ No
Do you have a cold, fever, or acute illness?	☐ Yes	☐ No
Has a physician told you not to have flu shot?	☐ Yes	☐ No
Do you have a history of Guillain-Barre' Syndrome or active neurological disorder?	☐ Yes	☐ No
Have you had an adverse reaction to another vaccine?	☐ Yes	☐ No
Have you received the pneumococcal vaccine one or more times in the past? If yes, when?	☐ Yes Date:	☐ No

THESE BOXES FOR CLINIC USE ONLY

☐ INFLUENZA VACCINE

MFR: ____________________

LOT: ____________________

☐ Right Deltoid: __________ Nurse Initials
☐ Left Deltoid: __________ Nurse Initials

☐ PNEUMOCOCCAL VACCINE

MFR: ____________________

LOT: ____________________

☐ Right Deltoid: __________ Nurse Initials
☐ Left Deltoid: __________ Nurse Initials

PAYMENT INFORMATION

☐ 90658 Flu Injection
G0008 Dx V04.81 $__________

☐ 90732 Pneumonia Injection
G0009 DxV03.82 $__________

I HAVE BEEN GIVEN A COPY OF THE VACCINE INFORMATION SHEET ☐ YES ☐ NO

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES and WRITTEN PERMISSION TO USE OR DISCLOSE HEALTH INFORMATION

I have received a copy of the Notice of Privacy Practices from the Wayne County Department of Public Health and understand that I may contact the person named in it if I have questions about the notice. I further expressly and voluntarily consent for the Wayne County Department of Public Health to use and disclose my health/medical information, as stated in the Notice of Privacy Practices, unless I request otherwise.

CLIENT SIGNATURE | DATE | WITNESS SIGNATURE | DATE

PRINT NAME | NURSE'S SIGNATURE | DATE