# Pneumococcal Vaccination Assessment, Release & Consent Form

**(Please print)**

Name_____
Date_____
(Individual receiving vaccination)

Address_____

City_____State_____Zip_____Birth date ____/____/____

County of Residence_____Gender M_____ F_____

Physician_____

Address_____

**DO YOU HAVE MEDICARE, PART B? _____Yes _____No**

**IF "YES" FILL IN YOUR NUMBER AND LETTER IN THE SPACES BELOW:**

____ ____ ____ - ____ ____ - ____ ____ ____ ____ - _____
(Medicare Number) (Letter)

1. Have you ever been vaccinated for pneumonia? ___Yes ___No ___Not Sure
2. Are you allergic to thimerosol-containing products (eye contact lens solution) or mercury-containing products (merthiolate)? ___Yes ___No
3. Were you over age 65 when you received the pneumonia shot? ___Yes ___No ___Not Sure

I have read the information or have had the information explained to me. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and risks of pneumococcal vaccine and ask that the vaccine be given to me, or to the person named above for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination. I authorize billing of this vaccination to Medicare, Part B.

Signature:_____

**FOR NURSES USE ONLY:**

SITE: RD/LD LOT #:_____EXPIRATION DATE_____
MANUFACTURER:_____ADMINISTERED BY:_____