PNEUMONIA VACCINATION ASSESSMENT & CONSENT FORM

☐ Billed
☐ AR

Yes	No	
☐	☐	Are you sick with a fever greater than 100 degrees Fahrenheit?
☐	☐	Have you had a cold or other respiratory infection in the last week?
☐	☐	Did you start taking an antibiotic within the last 48 hours?
☐	☐	Do you have Asthma, Diabetes, or other chronic condition?
☐	☐	Are you a smoker?
☐	☐	Are you currently receiving radiation, chemotherapy or immunosuppressive therapy? Last Tx? _____ Next Tx? _____
☐	☐	Have you had another immunization in the last 14 days? If yes, please list _____
☐	☐	Are you pregnant or a nursing mother?
☐	☐	Have you had the pneumonia vaccine in the past? If yes, when? _____. Which vaccine did you receive? ____ PCV13 or ___PPSV23 If so, did you experience a local reaction? Yes \ No. If yes, please describe _____
☐	☐	Have you ever had a reaction to a shot?
☐	☐	Have you ever had a severe allergic reaction? (food, medicine, flu shots, other), i.e. hives, breathing difficulty, shock, requiring emergency medical treatment or within 48 hours of a previous vaccine? If yes, specify _____

QUESTIONS

If you have any questions about the Pneumonia Disease or the Pneumonia Vaccination, please ask the nurse for clarification now or call your doctor before requesting the vaccine. If you have any questions or concerns following the vaccination, please call the MC VNA at 248-967-1440. If you experience any adverse effects from the Pneumonia Vaccination, please contact your physician and notify the MC VNA (also notify your employer if you received your vaccination at work).

CONSENT AND RELEASE FOR INFLUENZA VACCINE

- I have read the information on the Vaccination Information Statement regarding the Pneumococcal Vaccine. I have received a copy of the Vaccine Information Sheet to keep for my records. I have had an opportunity to ask questions, and my questions have been answered to my satisfaction. I understand the benefits and risks of the Pneumococcal Vaccination as described. I request that the vaccine be given to me. I understand the vaccination is being provided by MC VNA. **I expressly release MC VNA from any liability resulting from the Pneumococcal Vaccine.**
- I agree to remain under observation for at least 15 minutes. Should I leave before that period lapses, I expressly release MC VNA from any liability resulting from any adverse reaction to the vaccine which may occur during that period and thereafter. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense.
- I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I understand side effects may include, but are not limited to: pain, swelling, itching, and redness at the injection site, fever and difficulty breathing. Severe reactions may include anaphylaxis and death.
- In the event a MC VNA employee is exposed to my blood or other body fluids, I agree to have my blood tested for HIV and Hepatitis and have the results released to MC VNA/exposed person, but not to anyone else unless required/authorized by law.
- I acknowledge that I have received written information on MC VNA's "Notice of Privacy Practices" prior to the provision of service, and I have had the opportunity to have my questions answered.
- Unless cash\check are indicated below, I wish to have MC VNA bill my insurance for the cost of my shot. MC VNA agrees to accept provider payment.
- I acknowledge that I am responsible to reimburse the MC VNA for charges not covered by my insurance.

CLIENT INFORMATION

Legal Name *(as it appears on card)* _____ ☐ M ☐ F Birthdate _____ Age _____ Weight (if < 110 lbs) _____

Street Address / Apt. No. _____ City _____ State _____ ZIP _____ Telephone _____

Client has one of the following insurance plans with VACCINE COVERAGE? ☐ BCBS* ☐ BCN* ☐ Medicare Part B

☐ Cash - Amt: _____ ☐ Check - Number\Amount: _____

***Blue Cross® Blue Shield® of Michigan**
***Blue Care Network of Michigan**

Insurance Contract # _____ Responsible Party or Cardholder Information _____ Responsible Party Birthdate _____

Signature of Client/Guardian _____ Date _____ Email Address _____

Clinic Name/Date: _____

TO BE COMPLETED BY CLINIC STAFF

Dose: 0.5 cc PPSV 23 ☐ Right Deltoid IM ☐ Left Deltoid IM

Manu/Lot #/Exp _____ Nurse Signature _____ Date _____