



Screening and Consent Form for Immunization with Pneumonia Vaccine 2010-2011

PPSV protects against 23 types of pneumococcal bacteria, including those most likely to cause serious disease.

The patient or guardian must receive a copy of the Pneumococcal Polysaccharide Vaccine VIS **10/6/09** prior to receiving the vaccine. Go to <http://www.cdc.gov/vaccines> or www.immunize.org/vis for copies of VIS in other languages.

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____ Gender: M F

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone (___) ___ - _____ Medicare: YES NO

If you are 65 years or older, have you received a dose of the pneumonia vaccine within the past 5 years? YES NO

Please answer these questions by checking the boxes.	Yes	No	Unknown
1. Is the person wishing to be vaccinated pregnant ?			
2. Is the person wishing to be vaccinated younger than 2 years of age?			
3. Has the person wishing to be vaccinated ever had a life threatening allergic reaction to a previous dose of pneumonia vaccine?			
4. Has the person wishing to be vaccinated been told by a doctor NOT to have the pneumonia vaccine?			
5. Is the person wishing to be vaccinated ill today?			

I believe I understand the benefits and risks of the vaccine, and ask that the pneumonia vaccine be given to me or to the person named above (for whom I am authorized to make this request).

Signature of Person to Receive Vaccine
(or parent or guardian, if recipient is a minor)

Date

Name of Parent or Guardian,
(if recipient is a minor)

PROVIDER USE ONLY

If "NO" is checked to All above screening questions and the consent signed, administer the influenza vaccine per the NextCare Administration and Reporting of Vaccines Policy and Care Pathways.

If "YES" is checked on Any of the above screening questions, then the vaccine cannot be administered under standing orders. Please advise patient to consult their PCP or a NextCare Provider may be consulted.

Manufacturer: _____ Lot #: _____ Expiration Date: _____ Site: RD LD

Date: _____ Time: _____ Admin by: _____ Clinic: _____

Give the patient a copy of this form or document vaccination in the patient's immunization record.

Scan this form into the patient's EMR. If the patient is a minor, comply with all state laws regarding mandatory reporting of immunizations.