Rambo Memorial
HEALTH CENTER

☐ Pneumovax-23
☐ Tdap
☐ Prevnar –13

Please PRINT: **Adult Vaccines Consent Form (Please fill out completely)**

Date: _____ Primary Care Doctor: _____

Name: _____ Medicare #/Plan: _____ /

First MI Last Medicaid #/Plan: _____ /

STREET ADDRESS: _____ Insurance: Yes ☐ No ☐

(NO P.O. BOX) Not covered by Insurance: Yes ☐ No ☐

City: _____ State: _____ Zip: _____ County: _____

Sex: M ☐ F ☐ Birthdate: – – Age: _____ Phone: _____

MM/DD/YYYY

E-Mail: _____

By signing this form, I agree to the following: I understand there is always a possibility of an adverse reaction to any vaccine or drug. I have been offered a copy of the CDC Vaccine Information Sheet. I have been given the opportunity to ask questions, which were answered to my satisfaction. I understand the benefits and risks of this vaccine and request it be given to me or the person named above for whom I am authorized to make this request.

For Medicare Recipients: I authorize the release of any medical or other information necessary to process this claim. I also request Medicare payment be made to the party who accepts assignment.

HIPAA: I have been offered the Agency's Notice of Privacy Practices and understand that my protected health information may be used by the Agency as described in the notice.

Please answer the following questions:

1.	Have you ever received a dose of Pneumovax23 (pneumonia)? If so, when?	Yes ☐	☐ No
2.	Have you ever received a dose of Boostrix (tetanus, diphtheria, pertussis)? If so, when?	Yes ☐	☐ No
4.	Have you ever had a serious allergic reaction to a previous dose of Pneumovax or Boostrix?.....	Yes ☐	☐ No
5.	Do you now have a fever or are moderately ill?	Yes ☐	☐ No
6.	Are you allergic to neomycin or gelatin?.....	Yes ☐	☐ No
7.	Do you have a history of Guillain-Barre' Syndrome?	Yes ☐	☐ No
8.	Are you receiving chemotherapy or radiation therapy?	Yes ☐	☐ No
9.	Are you pregnant or a nursing mother?.....	Yes ☐	☐ No
10.	Do you have any disease that has weakened your immune system (HIV, AIDS, Lupus)?.....	Yes ☐	☐ No
11.	Have you received any blood products or any immunoglobulins in the last 3 months?	Yes ☐	☐ No

Signature of Patient or Guardian: _____

* If not patient's signature, relationship to patient _____

For Clinic Use Only

Date: _____ **Given By / Credentials:** _____

Dose: _____ **Site Given:** **RA LA RT LT** **VIS GIVEN: [ ] YES** _____

[ ] Pneumovax 23 **[ ] Boostrix** **[ ] Prevnar 13** **VIS DATE:** _____

Manufacturer **Lot #:** **Exp:**