BENTON-FRANKLIN HEALTH DISTRICT

INFLUENZA and PNEUMONIA VACCINE

I have read the **Influenza Vaccine (2004/2005) What you need to know before you or your child gets the vaccine** statement sheet, and have read or have had explained to me the information in this sheet about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine. I ask that the influenza vaccine be given to me or to the person named below for whom I am authorized to make this request.

Patient's or Guardians signature – My signature in the box below authorizes the release of my medical or other information necessary to process this claim, and request payment of government benefits be paid to the Benton Franklin Health District. I further acknowledge receipt of the **Notice of Privacy Practices**.

Location: TRAC **Account # _____ - _____**

Information About Person to Receive Vaccine (Please Print)			
Last Name	**First Name**	**MI:**	**Date of Birth**
Medicare/Medicaid Number: (Copy from card - include all characters)		**Age**	**Social Security #**
Address		**Phone Number**	
City	**State**	**Zip**	**Sex** ☐ **M** ☐ **F**
Signature of Patient or Guardian X_____	**Print Name of Parent for Minors** _____	**Date Vaccinated** _____	

FLU			***Clinic Use Only***	***PNEUMOCOCCAL***	
Vaccine Manufacturer: **Aventis**	Vaccine Lot #:	Expiration:	Vaccine Manufacturer: **Merck**	Vaccine Lot #: **0486P**	Expiration: **2-17-2006**
Site: ☐ **LD** ☐ **RD**	First Flu Shot? ☐ **YES** ☐ **NO**		Site: ☐ **LD** ☐ **RD**		
Signature and Title of Vaccine Administrator **X** _____			_____ Provider #	_____ Date	

Pneumococcal Consent:

I have read or had read to me the information on this form about pneumococcal disease and pneumococcal polysaccharide vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the pneumococcal vaccine and request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

X_____ _____

Signature of person to receive vaccine or authorized person. Date

Nursing Encounter				***Billing Use***	
124 **Adult Flu** _____	V04.81	132 **Adult Pneumonia** _____	V**05.8**	**Charge $**	**Manual Receipt #**
123 **Infant Flu** _____	V04.81	142 **Child Pneumonia** _____	**V05.8**	**Paid $**	
191 Child Flu _____	V04.81	198 **Flu Mist** _____	**V04.81**	**Cash** ☐	**Encounter #**
		128 **Adult TD** _____	**V05.9**	**Check #** _____	