Aegis #: _____
Clerk Initial: _____

Johnson County Health Department
VACCINE CONSENT FORM

TO BE COMPLETED BY HEALTH DEPARTMENT

VACCINE	LOT#	CPT#	Carton NDC # / MFR	Exp date	Site of Vaccination (Circle One)	Route
ð Fluzone High Dose (65 yrs & up)	UT7715AA-CP	90662	49281-0122-65 SP	6/30/23	LA / RA	IM
ð Fluzone/Fluarix/Flulaval Quad – PF (6 mths & up)	FLUZONE UT7681JA-CP FLUARIX G2979-CP 9337Z D34TF	90686	49281-0422-50 SP 58160-0890-52 GSK	6/30/23	LA / RA LAT / RAT	IM
ð Flumist Quad (2-49 yrs)		90672		12/14/22		Nasal
Pneumovax 23	U022819-CP U035117	90732	00006-4837-03 MK	1/14/23 08/18/2023	LA / RA	IM
Prevnar 13	EE7120-CP FC0406	90670	00005-1971-02 PZ	06/30/2023 08/18/2023	LA / RA	IM
Prevnar 20	FL2935-CP	90677	00005-20000-10	08/31/2023	LA / RA	IM

Abbreviations: Quad – Quadrivalent; MDV – Multi dose vial; GSK – GlaxoSmithKline; SYR – Syringe; PF – Preservative free; Mk – Merck; MED-Medimmune; SP – Sanofi; Pz - Pfizer; VL – Vial

VIS given: Inactive Flu-8/6/21 Active Flu-08/6/21 PPV 23-10/30/19 Prevnar 13-2/4/22 Prevnar 20-2/4/22

Date VIS Given: ____/____/____

Signature of nurse: _____ **Date:** _____

Statement of Understanding - I have read or have had explained to me the information on this form about pneumonia and/or influenza 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 vaccine and request that the vaccine be given to me or to the person named below for whom I am authorized to make this request.

- **HIPPA** - I have received the NOTICE OF PRIVACY POLICY FORM for the **Johnson** County Health Department.
- **Payment** - I understand that if my insurance is denied for any reason, the **Johnson** County Health Department will bill me for the vaccine administered.

Please PRINT All Information Below

First Name: _____ **Middle:** _____ **Last Name:** _____

Date of Birth: _____/_____/_____ **Age:** _____ **Race:** _____ **Gender** *(Circle)*: M F

Phone #: _____-_____-_____ **SSN:** _____-_____-_____

Address: _____
Street Address

_____
City State Zip

Allergies: ☐No known allergies
☐ Allergies, Please list: _____

Signature of person to receive vaccine or person authorized to make request:

Signature: _____ Date:_____