# Statement of Permission and Assignment
## Influenza and/or Pneumococcal Vaccine

Instructions: Print name exactly as it appears on your Medicare or Medicaid card.

Name: _____
Last First Middle Date of Birth

Address: _____
Number & Street City State Zip Phone Number

_____ M / F Y / N _____ - - _____.
Race Sex Hispanic Social Security Number

### Insurance Information

Do you have…….. Insurance, Medicare or Medicaid? **(circle one)**

*COPY OF CARD MUST BE ATTACHED TO THIS FORM.*

### Pre-Vaccination Evaluation

**I have read and understand** the information provided to me concerning the receiving of vaccines for influenza (Current VIS form) and/or pneumococcal pneumonia (Current VIS form) and have had the opportunity to ask questions. I understand that being allergic to eggs may be a reason to not receive the vaccination for influenza.

1) Are you allergic to eggs? Yes No
2) Have you ever had an influenza vaccination before? Yes No
3) Have you ever had a serious allergic reaction to influenza vaccine? Yes No
4) Have you ever had a pneumonia vaccination before? Yes No
5) Have you ever had a serious allergic reaction to pneumonia vaccine? Yes No
6) Do you presently have a fever with a temperature above 100 degrees? Yes No
7) Are you currently pregnant? Yes No N/A

**Pregnant Women Only**

A flu shot has been recommended for me since I am pregnant but I decline at this time.

Signature: _____

Date: _____

### Signed Patient Consent

**By placing my initials in the space(s) provided, I give my permission** to receive:

INFLUENZA VACCINE_____(**initials**) and/or PNEUMONIA VACCINE_____(**initials**).

I hereby acknowledge that I have received a copy of the "Notice of Privacy Practices" for the Carteret County Health Department_____(**initials**).

I authorize the Carteret County Health Department to submit a claim on my behalf to Insurance, Medicare or Medicaid. I also authorize release of any information necessary in processing my claim. I request payment be made to the Carteret County Health Department on my behalf. _____***(initials)***.

**Signature**: _____ **Date**: _____

Insurance Information: (used to file for the administration Influenza and/or Pneumonia vaccine only)

Primary Insurance Plan Name_____

Subscriber ID _____

Group Number _____

Primary Subscriber information ***if different*** from patient:

Name _____

Date of Birth _____

Patient's Relationship to Subscriber_____