MULTI-DOSE IMMUNIZATION CONSENT FORM

I have been given a copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s)" for the vaccine(s) checked below. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request. I consent to Medicare Part B billing if applicable.

☐ Influenza ☐ Pneumococcal

Medicaid/Medicare #					
Last Name	First Name	MI	Sex ☐ Male ☐ Female	Birthdate	Phone #
Social Security #	Race ☐ White ☐ Asian or Pacific Islander ☐ Black/African American ☐ Other ☐ Indian ☐ Unknown		Ethnicity ☐ Non-Hispanic ☐ Cuban ☐ Unknown ☐ Mexican ☐ Central//South American ☐ Puerto Rican ☐ Other & Unk. Hispanic		
Street Address	City		State	Zip Code	
Signature of person authorized to make the request			Date		

FOR CLINIC USE ONLY

VACCINE/ROUTE	INJECTION SITE		VACCINE MFG/ LOT#	VACCINE EXP. DATE	SIGNATURE OF VACC. ADMIN.
	L Delt	R Delt	CSL Limited Afluria	6/8/2010	
Influenza IM			01849211A		