

**Attachment 2**  
**Pneumococcal Vaccine Status**  
**Questionnaire and Consent for Family Member or Guardian**

Name of long term care facility \_\_\_\_\_

Name of resident \_\_\_\_\_

Please check one of the following three boxes and complete the remainder of the information as requested:

<p><input type="checkbox"/> I hereby request that pneumococcal vaccine be given to the resident named above for whom I am authorized to make this request.</p> <p><input type="checkbox"/> The above patient has had pneumococcal vaccine:</p> <p>Date _____</p> <p>If date unknown: Doctor who gave the vaccine _____</p> <p>Doctor's telephone number _____</p> <p><input type="checkbox"/> I decline to give consent for vaccine administration</p>
--

Signed \_\_\_\_\_

Print name \_\_\_\_\_

Date \_\_\_\_\_

Phone # \_\_\_\_\_

Return questionnaire to:

Contact person \_\_\_\_\_

Facility name \_\_\_\_\_

Facility address \_\_\_\_\_

\_\_\_\_\_