# PNEUMOVAX 23 AND PREVNAR 13
# VACCINE ADMINISTRATION RECORD

"I have read or have had explained to me the information in the Vaccine Information Statement(s) (VIS), or the important information statement(s) about the vaccine(s) listed below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) listed below, and ask that the vaccine(s) be given to me or to the person named below for whom I am authorized to make this request."

**INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT)**

| NAME: LAST | FIRST | M.I. |
|---|---|---|
| | | |

| STREET ADDRESS: | CITY | COUNTY | STATE | ZIP |
|---|---|---|---|---|
| | | | | |

| DATE OF BIRTH | AGE | SEX ○ M or F ○ | PHONE |
|---|---|---|---|
| | | | |

| SOCIAL SECURITY # (Optional) | MARITAL STATUS: | RACE |
|---|---|---|
| | | |

**SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE REQUEST AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE (NPP) FORM AND AUTHORIZATION TO BILL:**

**X**_____ **DATE** _____

**If insurance does not pay for vaccine, patient will be responsible for payment.**

**(If vaccine recipient is under 18 years of age, fill out the shaded section below)**

| **Parent or Guardian Name: Last** | **First** | **Middle Initial** | **Maiden** |
|---|---|---|---|
| | | | |

FAMILY PHYSICIAN: _____PHONE:_____

In order for Medicare to pay for the vaccine, please complete the information below:

EXACT NAME ON MEDICARE CARD_____

MEDICARE # _____

**FOR OFFICE USE ONLY**

Form checked, insurance card seen (Name & Part B) VIS given and NPP witnessed by _____ (Initials)

BILL MEDICARE PART B ONLY _____

PAID $_____ CASH ☐ CHECK ☐ # _____ RECEIPT #_____ CREDIT CARD ☐ CASHIER INITIALS _____

CC TYPE: Visa / MasterCard/Other CC#_____ EXP DATE:_____ CC SECURITY#_____

**Please turn page over and complete side 2** →

Name: _____ DOB: _____ Age: _____

**Please Circle *yes* or *no* to the following questions:**

1. Are you 19-64 years of age? *Yes* *No*
2. Have you had a prior pneumonia vaccination? Type: _____ *Yes* *No*
3. Has it been at least 5 years since your last pneumonia shot? *Yes* *No*
4. Are you 65 years or older? *Yes* *No*
5. Do you smoke? *Yes* *No*
6. Do you have asthma, COPD, emphysema or other chronic lung diseases? *Yes* *No*
7. Do you have diabetes? *Yes* *No*
8. Do you have long-term heart, liver or kidney problems? *Yes* *No*
9. Do you take long-term immune suppressive therapy (radiation, corticosteroids, etc)? *Yes* *No*
10. Have you had an organ or bone marrow transplant? *Yes* *No*
11. Have you ever had a reaction to ANY vaccine? *Yes* *No*
12. Do you have a fever or other illness today? *Yes* *No*

| **************************FOR CLINIC/OFFICE USEONLY************************** | | |
|---|---|---|
| **Queen Anne's County Department of Health**<br>**206 N. Commerce Street**<br>**Centreville, MD 21617** | | **Alternate site:** |
| **DATE of VIS OR IIS:** | **4/24/15** | **11/5/15** |
| **DATE VIS/IIS GIVEN:** | | |
| **VACCINE GIVEN:** | **Pneumovax 23/Pneumococcal Polysaccaharide (PPSV23)** | **Prevnar13/Pneumococcal Conjugate (PCV13)** |
| **DATE VACCINE ADMINISTERED:** | | |
| **VACCINE MANUFACTURER:** | | |
| **VACCINE LOT NUMBER & EXPIRATION DATE** | | |
| **SITE OF INJECTION:** | | |
| **SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR:** | | |

**Revised 9-20-16**