

NYS Veterans Home at Batavia Staff

2025-2026 Influenza/Pneumococcal Immunization Consent From

Name (Please Print) _____ Date of Birth _____ Sex _____ County of Residence _____

Address _____ City _____ State _____ Zip _____

Phone _____ For Persons Under 19 Years Old, Mother's Maiden Name _____

Medicare Claim Number _____ Doctor's Name _____

Health Insurance Provider _____ Doctor's Address _____

Insurance Policy Number _____ Clinic Office Site Where Vaccine Administered _____

New York State Veterans Home at Batavia

Please complete the questions below.

Are you currently sick with a fever? Yes No

Have you ever had a life-threatening allergy to any component (or Part) of the flu or pneumonia vaccine? Yes No

If yes, please describe: _____

Have you ever developed Guillain-Barre-Syndrome within 6 weeks of receiving flu vaccine? Yes No

Have you ever had a pneumonia shot? Yes No

Are you a smoker or have a chronic medical condition such as asthma, heart, or lung disease? Yes No

If yes, please describe: _____

Have you ever had a severe life-threatening allergy to eggs or egg products? Yes No

Are you currently pregnant? Yes No

Do you have a history of asthma or wheezing? Yes No

Do you have a weakened immune system or have close contact with a person with an extremely weakened immune system who needs special care? Yes No

Have you received any other vaccinations within the last 4 weeks? Yes No

Have you taken any antiviral medication for the flu within the last 48 hours? Yes No

I have read, or had explained to me, the Vaccine Information Statement about **influenza** vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the **influenza** vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose. I have received a copy of the Patient Bill of Rights.

I decline to receive the influenza vaccine ☐

I consent to receive the influenza vaccine ☐

Signature _____ Date _____

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I have read, or had explained to me, the Vaccine Information Statement about **pneumococcal** vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the **Pneumococcal** vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose. I have received a copy of the Patient Bill of Rights.

I decline to receive the pneumococcal vaccine ☐

I consent to receive the pneumococcal vaccine ☐

Signature _____ Date _____

Area Below to be Completed by Nurse

Influenza Vaccine

Administration Date _____

Administration Site ☐ Left deltoid ☐ Right deltoid

Dosage ☐ 0.5 ml ☐ 0.25 ml ☐ LAIV

Manufacturer & Lot # & Exp. Date :

VIS Date _____

Nurse Signature _____

Next Immunization Due: ☐ Next Year ☐ 4 Weeks ☐ Other

Pneumococcal disease Vaccine

PNA Vaccine type: PVR20 PCV13 PVR23

Other: _____

Administration Date _____

Administration Site ☐ Left deltoid ☐ Right deltoid

Manufacturer & Lot # & Exp. Date :

VIS Date _____

Nurse Signature _____

Next Immunization Due: ☐ None Needed ☐ Other _____