Wellstar
AFFILIATED WITH MEDICAL COLLEGE OF GEORGIA

FORMERLY Health

Wellstar MCG Health Immunization Program
LETTER OF AGREEMENT

First Name _____ **Last Name**_____

DOB_____ **Age**_____ **Home Phone**_____

Home Address_____

City_____ **State**_____ **Zip Code**_____ **Mothers Maiden name (For GRITS)** _____

Primary Care Provider (PCP) _____ **PCP Phone** _____

Vaccine Requested

€ Flu Shot € Flu Nasal Spray € Flu HD (ages 65+) € Pneumonia

€ Shingles € Tdap € Other_____

The following questions will help us determine your eligibility to be vaccinated today.

1. Do you feel sick today? **YES** **NO**
2. Do you have allergies to medications, food, or vaccines? **YES** **NO**
   (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, thimerosal)
3. Have you received any vaccinations or skin tests in the past 4 weeks? **YES** **NO**
   If yes, please list: _____
4. Have you ever had a serious reaction to a flu vaccine or any other vaccine in the past? **YES** **NO**
5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barre syndrome (a condition that causes paralysis), or other nervous system problem? **YES** **NO**
6. Are you 65 years of age or older? **YES** **NO**
7. Do you smoke? **YES** **NO**
8. Do you have a chronic condition or long-term health problem? **YES** **NO**
   If yes, please check all that apply

   € Anemia € Asthma € Diabetes € Heart Disease

   € Kidney Disease € Liver Disease € Lung Disease € Other_____
9. If you answered YES to question #7, 8, or 9, have you ever had a pneumonia vaccine? **YES** **NO**
10. Have you ever had a shingles vaccination (for patients 60 years of age and older only)? **YES** **NO**

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11. Are you a healthcare worker?	**YES**	**NO**
12. For women: are you pregnant or considering becoming pregnant in the next month?	**YES**	**NO**

FOR LIVE VACCINES

13. Are you currently on home infusions, weekly injection, steroid therapy, anticancer drugs, or radiation treatments?	**YES**	**NO**
14. Do you have cancer, leukemia, lymphoma, HIV/AIDS, or any other immune system disorder or are you in contact with anyone who has a severely weakened immune system?	**YES**	**NO**
15. Have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?	**YES**	**NO**
16. Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only)	**YES**	**NO**
17. If the patient receiving the vaccine is under 5 years old, is there a history of asthma or wheezing? (for FluMist® only)	**YES**	**NO**
18. Does the patient have a nasal condition serious enough to make breathing difficult, such as a very stuffy nose? (for FluMist® only)	**YES**	**NO**

I have read the Vaccine Information Statement or have had explained to me the information about vaccinations to be given. I had the chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risk involved with receiving vaccination and ask that vaccine(s) be given to me or to the person name on this form for whom I am authorized to make the request. I authorize the release of medical or other information necessary to process the claim. By signing this form, I also acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____

Signature of Person receiving vaccine or parent/guardian Date

Vaccine Type: _____

Lot: _____

Expiration Date: _____

Site: Left Arm / Right Arm

Immunizing Pharmacist/Nurse: _____

Insurance Information:

Cardholder ID: _____

RxGroup Name/Number: _____

Bin number: _____

PCN number: _____