



IMMUNIZATION ADMINISTRATION CONSENT FORM
FLORIDA DEPARTMENT OF HEALTH IN ALACHUA COUNTY

NAME _____
LAST FIRST MI
YOUR AGE TODAY _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____
RACE _____ SEX _____ COUNTY OF RESIDENCE _____ TELEPHONE () _____
MAILING ADDRESS _____
CITY _____ STATE _____ ZIP _____

PLEASE ANSWER THE FOLLOWING QUESTIONS

DO YOU HAVE ANY ALLERGIES: _____

I AM REQUESTING A (CIRCLE ONE): FLU SHOT FLU MIST I AM REQUESTING A PNEUMONIA SHOT: Yes ☐ No ☐

"I have read or have had explained to me the information about influenza/pneumonia and influenza/pneumonia vaccine(s). I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza/pneumonia vaccine(s) and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request."

I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician or organization furnishing services or authorize such physicians or organization to submit a claim to Medicare for payment for me. I understand if I am a member of an HMO or Medicare is not my primary insurance; I will be personally responsible for any charges not covered by Medicare assignment. By my signature below, I acknowledge receipt of the Notice of Privacy Practices form and the Vaccine Information Statement.

Signature of Recipient/Guardian: _____ Date _____

If someone other than client, print name: _____ Relationship to client _____

***STAFF USE ONLY ***

DATE VACCINATED: _____	CLINIC SITE _____
FLU VACCINE VIS 01/31/25 _____	PNEUMONIA VACCINE VIS _____
MFG/LOT # _____	MFG/LOT# _____
SITE/ROUTE LDT RDT IM IN _____	SITE/ROUTE LDT RDT IM _____
NURSE _____	NURSE _____

Client Label

Last Name _____
First Name _____
Date Of Birth _____

Date

Appt Time

Work Up

IN

Out

Cashier Only

Cashier Initials _____

Copay Paid	Y	N	\$	_____
SFS Paid	Y	N	\$	_____
Prev Bal Paid	Y	N	\$	_____
No Payment	Y	N	\$	_____

Lab Orders