**INFLUENZA IMMUNIZATION-INFORMED CONSENT**

***Please initial next to the appropriate choice below:***

\_\_\_ ***YES*** – ***I HEREBY GIVE*** the facility permission to administer an Influenza Vaccination. I understand that this immunization is to be given only one (1) time. To the best of my knowledge, I have not received an Influenza Vaccination

By choosing this option and signing below, I am acknowledging that I have been informed that as a result of this vaccination, I may experience some side effects such as:

\*Slight discomfort at the injection site \*Soreness of the arm

\*Redness on the arm \*Slight fever (occasionally)

\*Muscle aches (occasionally) \*Joint aches (rarely)

\*Rash (rarely)

\_\_\_ ***NO - I DO NOT*** give the facility permission to administer an Influenza Vaccination.

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 Printed Resident’s Name Date

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**PNEUMOCOCCAL IMMUNIZATION-INFORMED CONSENT**

***Please initial next to the appropriate choice below:***

\_\_\_ ***YES*** – ***I HEREBY GIVE*** the facility permission to administer a Pneumococcal Vaccination. I understand that my physician may order this vaccination more than one time at different intervals in my lifetime based on recommendations related to risk factors including age and disease diagnosis.

By choosing this option and signing below, I am acknowledging that I have been informed that as a result of this vaccination, I may experience some side effects such as:

\*Slight discomfort at the injection site \*Soreness of the arm

\*Redness on the arm \*Slight fever (occasionally)

\*Muscle aches (occasionally) \*Joint aches (rarely)

\*Rash (rarely)

\_\_\_ ***NO - I DO NOT*** give the facility permission to administer a Pneumococcal Vaccination.

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 Printed Resident’s Name Date

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