PREVENTIVE HEALTH SOLUTIONS

_____ Yes, I want to receive my **FLU** (**Influenza**) Vaccine

_____ Yes, I want to receive my **TDaP** (**Tetanus, Diphtheria, Pertussis**) Vaccine

_____ Yes, I want to receive my **Hepatits A** Vaccine (2 doses)

_____ Yes, I want to receive my **Hepatits B** Vaccine (3doses)

_____ Yes, I want to receive my **MMR** Vaccine

_____ Yes, I want to receive my **Varicella** Vaccine

_____ Yes, I want to receive my **PCV 13** (**Pneumonia**) Vaccine (**65 and older**)

_____ Yes, I want to receive my **PCV 23** (**Pneumonia**) Vaccine

_____ Yes, I want to receive my **Shingles** (**Shingrix**) Vaccine (**50 and older**)

Before administration, PHS will verify insurances to confirm vaccines will be covered 100%
PHS follows the CDC guidelines for any vaccines listed

Insurance and Contact Information

Name: _____ Date of Birth: _____

Phone #: _____ Email: **_____**

Insurance Carrier: _____

Member ID / Social Security #: _____

Employer / Dept: _____

Please bring the following with you on the day of the vaccination:

- Insurance Card
- Vaccine Records
- Please turn in this consent form by **October 8, 2018**