

FIRST NAME

DATE OF BIRTH

LAST NAME

m m d d y y y y

Mailing Address

CITY

STATE

Mail completed top form to:  
NM Immunization Program  
PO Box 26110  
Santa Fe, NM 87502-6110

ZIP CODE

**Please fill circles COMPLETELY**

Sex

- Male  
 Female

Ethnicity

- Hispanic  
 Non-Hispanic

Race

- Native American  Black or African-American  Other  
 Asian  White

Health Plan

Medicare number (required if > 65)

Health Plan Patient ID #

Primary care physician

I have been given and have read, or have had explained to me, the information in the 'Vaccine Information Statement(s)' for the disease(s) and vaccine(s) checked below. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccines requested and also understand that I have the alternative to decline the vaccines. I ask that the vaccines signed for be given to me or the the person named for whom I am authorized to make this request. I request that payment of authorized benefits be made to the New Mexico Department of Health/Public Health Division/Immunization Program, for services furnished to me by that program. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

Signature of person to receive vaccine  
or person authorized to make request: \_\_\_\_\_

**FOR CLINIC USE ONLY (Enter numbers and fill appropriate circles completely)**

Clinic ID #

Date of Service

m m d d y y y y

**Patients in Level One have priority.**

**Fill in one and only one category:**

- Highest Priority (Level One)
- ≥ 65 years of age
  - Adult with Chronic disease
  - Pregnant
  - Nursing home/long term care/homeless shelter resident
  - Health care staff who provide direct client services
  - Household contact of caregiver of child < 6 mos.

High Priority (Second Level)

- Household members of other high risk individuals
- Age 50-64 years

Download at: <http://www.health.state.nm.us/immunize/forms/FLU-ENG.pdf>

- Manufacturer:  Sanofi Pasteur (Fluzone)  
 GlaxoSmithKline (Fluarix)  
 GlaxSmithKline (Flulaval)  
 Chiron (Fluvirin)

Lot #

Injection site

- Manufacturer:  Merck (Pneumovax)

Lot #

Injection site

Provider of vaccine: \_\_\_\_\_ Date: \_\_\_\_\_