PNEUMOCOCCAL VACCINATION CONSENT FORM

Patient Information:

First Name: _____Middle:_____Last name:_____

Screening for pneumococcal vaccine eligibility:

1. Have you ever had a life-threatening reaction to the pneumococcal vaccine? Yes No
2. Are you moderately or severely ill today? Yes No

If yes to any questions 1 then DO NOT vaccinate with pneumococcal vaccine.
If yes to question 2, vaccinate when patient has recovered.

I have read or had explained to me the Vaccination Information Statement about pneumococcal vaccination and I understand the benefits and risks of pneumococcal vaccination. I request that the pneumococcal vaccination be given to me (or the person named above for whom I am authorized to make this request).

Signature: _____ Date: _____

Name:_____Relationship to patient: _____

To be completed by person administering vaccine:

Today's date:_____Site of Injection (circle one): R L
Lot #:_____Expiration Date: _____
Medical Record #:_____Room #: _____
Administered by: _____