Shingles Vaccine Consent Form

Must be 50 years of age or older
Remain in the pharmacy for 10 minutes after injection

Schwieterman PHARMACIES & Compounding Center

PERSONAL INFORMATION					
FIRST NAME	MIDDLE INITIAL	LAST NAME			
ADDRESS		CITY	STATE	ZIP	
COUNTY	PHONE	☐ Female ☐ Male GENDER	DATE OF BIRTH	AGE	
PRIMARY CARE PROVIDER (PCP)		PHONE	FAX		
ADDRESS		CITY	STATE	ZIP	

SCREENING QUESTIONS	
Are you currently sick with a fever or any type of infection including tuberculosis?	☐ Yes ☐ No
Do you have a severe (life-threatening) allergy to any component (or part) of this vaccine, including gelatin and neomycin?	☐ Yes ☐ No
Have you ever had a severe (life-threatening) allergic reaction to a previous dose of any vaccine?	☐ Yes ☐ No
Do you have cancer, leukemia, lymphoma, HIV/AIDS, or another disease that affects the immune system?	☐ Yes ☐ No
In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐ Yes ☐ No
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐ Yes ☐ No
Have you received any vaccinations in the past 4 weeks?	☐ Yes ☐ No
For women: Are you breastfeeding, pregnant or is there a chance you could become pregnant during the next month?	☐ Yes ☐ No

Please remain in the pharmacy for 10 minutes following the vaccination. If you leave, you are doing so against medical advice.

I have read or have had explained to me the information in this pamphlet about shingles and the shingles vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of shingles and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request. I waive and release all claims I, or anyone claiming by or through me, now have or may hereafter acquire against Dr. James Schwieterman, MD, Schwieterman Pharmacies, and their respective employees for any damage or injuries if I, or the person named below for whom I am authorized to make this request, contact shingles, other diseases, or suffer any other adverse reactions following administration of this shingles vaccine. **I understand that I may be held responsible for charges that are not covered by my insurance. I understand that if I do not provide the proper insurance information I may also be held responsible for charges.** For Medicare Recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party that accepts assignment.

SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE THE REQUEST (PARENT OR GUARDIAN) **DATE**

----------FOR CLINIC/OFFICE USE ONLY----------

IMMUNIZER	TITLE	DATE OF IMMUNIZATION	VIS DATE

VACCINE	LOT #	EXP DATE	MFG	SITE OF INJECTION
Zostavax 0.65ml				☐ LA/SQ ☐ RA/SQ

INSURANCE	RX #	STORE
☐ Medicare ☐ Third Party ☐ Cash		

Time Reconstituted: _____ Time Administered: _____ Diluent Lot #/Exp Date: _____/_____ Updated August 2014