☐ Cy's ☐ Sinclair ☐ Tile ☐ Wanakah ☐ Kenmore ☐ Family Medical ☐ Larwood

SHINGLES VACCINE CONSENT FORM

Print Carefully:

Last Name _____ First Name _____ MI _____ Birth date _____ Age ____ M/F ____

Street Address _____ City _____ Zip code _____

Telephone Number _____

Yes No Are you 60 years of age or older?
Yes No Have you previously had a Shingles ☐(Zostavax) ☐(Shingrix) shot?
Yes No Have you ever had an allergic reaction to gelatin?
Yes No Have you ever had an allergic reaction to the antibiotic Neomycin?
Yes No Do you have any severe allergies?
Yes No Do you have a weakened immune system?
Yes No Are you taking any steroid or cancer treatment chemotherapy/radiation?
Yes No Have you had a Pneumonia shot or other live vaccine in the past 4 weeks?
Yes No Are you ill today or have a temperature?

Consent:

I have received the Shingles Vaccine Sheet (VIS) and have had the opportunity to ask questions.
I request that I receive the vaccine and will notify my primary health care provider that I have received the Shingles vaccine.
I authorize the release of information for payment or public health purposes.

Signature _____ Date _____

Vaccine Manufacturer- Merck **G S K**
☐ **Vaccine -** Zostavax (Shingles) ☐ **Shingrix**
Vaccine Lot Number _____

Site: RD LD

Administered/Title _____

Date _____