

# PNEUMOCOCCAL VACCINE CONSENT

## PATIENT AUTHORIZATION AND NOTICE

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

### ADULT IMMUNIZATIONS – Screening Questionnaire (PLEASE READ)

The following questions will help us determine which vaccines you may be given today. If you answer “YES” to any question, it does not necessarily mean you should not be vaccinated, it just means additional questions must be asked. **If a question is not clear, please ask your healthcare provider to explain it.**

### PNEUMOCOCCAL QUESTIONS:

Are you sick today?  YES  NO

Do you have allergies to medications, foods, or vaccines?  
*Including gelatin or the antibiotic neomycin or any other component of the shingles vaccine.*  YES  NO

Have you ever had a serious reaction after receiving a vaccination?  YES  NO

Do you have a long-term health problem with heart disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorders?  YES  NO

Do you have cancer, leukemia, AIDS, or any other immune system problems?  YES  NO

Do you take cortisone, prednisone, other steroids, or anticancer drugs or have you had radiation treatments?  YES  NO

Have you had a seizure or other nervous system problem?  YES  NO

During the past year have you received a transfusion of blood or blood products?  YES  NO

For women: Are you pregnant or is there a chance you could become pregnant?  YES  NO

Have you received any vaccinations in the past 4 weeks?  YES  NO

I certify that I have been given the PNEUMOCOCCAL CDC Vaccine Information Statement before my injection. I have reviewed the information sheet; understand the possible side effects and I feel I have no contraindications to the administration of the vaccine.

\_\_\_\_\_  
Signature of Recipient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Vaccine Manufacturer

\_\_\_\_\_  
Lot Number

\_\_\_\_\_  
Exp. Date

\_\_\_\_\_  
Signature of Nurse

Injection Site:

Right Arm

Left Arm