VACCINATION CONSENT FORM

Last Name	First Name	M/I	Date of Birth

Address	City	State	Zip Code

Phone Number	Male/Female	Family Physician

Which Vaccine are you receiving?

1. **Seasonal Influenza Vaccine** (Quadrivalent) ❒
2. **Boostrix** (TETANUS TOXOID , DIPHTHERIA TOXOID, ACELLULAR PERTUSSIS VACCINE) ❒
3. **Engerix-B** (HEPATITIS B VACCINE RECOMBINANT) ❒
4. **Menactra** (MENINGOCOCCAL POLYSACCHARIDE VACCINE) ❒
5. **Pneumovax/Prevnar** (PNEUMOCOCCAL VACCINE POLYVALENT) ❒
6. **Tubersol** (TUBERCULIN PPD) Dates Given:__________Read________

   Read by __________ Result Positive ❒ Negative ❒ ❒
7. **Shingrix** (ZOSTER VACCINE) ❒

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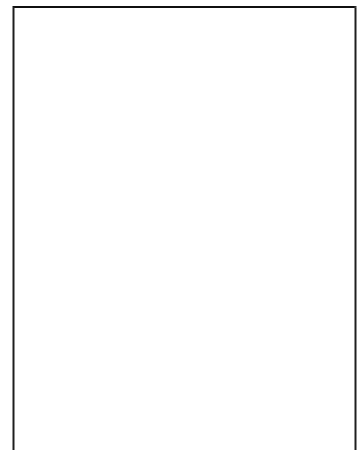
I have read or have had explained to me the information about the vaccine listed above. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of influenza/pneumonia vaccine and request that the vaccine be given to me or to the person named for who am I authorized to make this request.

I acknowledge receiving the pharmacy's notice of privacy policy.

X____ DATE ___________________________

(Signature of person to receive vaccine or authorized to make the request.)

Place Sticker Here



SITE OF INJECTION: ❒ LEFT DELTOID(ARM) ❒ RIGHT DELTOID(ARM)

SIGNATURE OF PERSON GIVING INJECTION	DATE VACCINATED