Pneumococcal Vaccine Consent Form

(PCV20)

Must be 19 years of age or older

Remain in the pharmacy for 10 minutes after injection

Aston Pharmacy
Home Health Center
"Where caring is the heart of our business"

PERSONAL INFORMATION

1/31/25 Vaccine Information Statement

Please scan and read.

Paper version available by request.

NAME		
ADDRESS		
CITY	ZIP	STATE
PHONE	DATE OF BIRTH	AGE
PRIMARY CARE PROVIDER (PCP)	PCP FAX	

SCREENING QUESTIONS

1. Are you 50 years old or older? If yes, skip to question 2	□ Yes □ No
1a. Are you 19-49 year of age and at an increased risk for Pneumococcal disease? Eg. weakened immune systems (due to conditions like HIV, cancer, diabetes, or certain medications), chronic lung conditions (like COPD or asthma), lack of a spleen or spleen dysfunction, and lifestyle factors such as smoking or living in crowded conditions, certain race/ethnicities such as Alaska Native, African American, American Indian	□ Yes □ No
2. Have you ever received a PCV? **If unsure, check "no" and let your vaccinator know.**	□ Yes □ No
3. Are you currently sick with a fever?	□ Yes □ No
4. Do you have a severe (life-threatening) allergy to any component (or part) of this vaccine, (eg. Diphtheria toxoid) including phenol?	□ Yes □ No
5. Have you ever had a severe (life-threatening) allergic reaction to a previous dose of any vaccine?	□ Yes □ No
7. For women: Are you currently pregnant or breastfeeding?	□ 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 been given the Centers for Disease Control and Prevention Vaccine Information Sheets. I have read these documents and have no further questions currently. I understand the risks and benefits of the vaccine. I request and voluntarily consent to receiving the pneumococcal vaccine and I acknowledge that no guarantees have been made concerning the vaccine's success. I understand the possible side effects and warnings and precautions that should be taken into consideration prior to administration of the vaccine and consent to emergency treatment if needed.

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.

Allergies or medical alerts: _____

Patient Signature: _____ Date: _____

Printed name of above: _____

For Office Use Only

Vaccine	Manufacturer	VIS Date	Lot #	Exp Date	Site/Route	Dosage Vol
Prevnar® 20	Wyeth	05/29/25			LD RD IM	0.5 mL

Signature of Vaccinator: _____ **Date of Admin:** _____

For office use only: _____Billed _____Scanned _____PIERS _____ faxed PCP