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

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

SCREENING QUESTIONS

Are you currently sick with a fever?	□ Yes □ No
Do you have a severe (life-threatening) allergy to any component (or part) of this vaccine, including phenol?	□ Yes □ No
Have you ever had a severe (life-threatening) allergic reaction to a previous dose of any vaccine?	□ Yes □ No
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 at this time. 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 alert: _____

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	02/04/22			LD RD IM	0.5 mL

Signature of Vaccine Administrator: _____ **Administration Date:** _____

For office use only: ____ *Billed* ____ *Scanned* ____ *PA SIIS*