

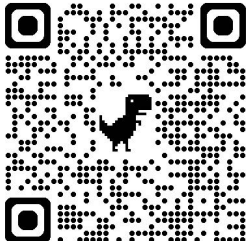
# Shingles Vaccination Consent Form and Record

Must be 50 years of age or older

Must remain in pharmacy for 10 minutes after injection



## PERSONAL INFORMATION

 <p>2/4/22 Vaccine Information Statement</p> <p>Please scan and read</p> <p>Paper copy available upon request.</p>	NAME:	
	DATE OF BIRTH:	PHONE:
	<input type="checkbox"/> FEMALE	<input type="checkbox"/> MALE
	AGE:	
	ADDRESS:	
	FAMILY DOCTOR:	
ALLERGIES/MEDICAL ALERT:		

## SCREENING QUESTIONS:

1. Have you received a shingles shot in the past? If so, Zostavax or Shingrix (circle one)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Are you currently sick with or without a fever?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Are you severely allergic to any component of Shingrix?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Are you immunosuppressed, on hemodialysis, undergoing radiation or chemotherapy?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Are you taking high dose corticosteroids or on immune modulating therapy?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Have you had TB, a bone marrow transplant or are you missing your spleen?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. Are you Latex allergic?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. Have you received a vaccine within the past 30 days? If so, which _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9. FEMALES: Are you pregnant or breastfeeding?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Note: If you answered YES to questions 2 through 5 you should NOT receive a Shingrix vaccine. If you answered YES to question 7 please request the use of LATEX-FREE gloves.

- Shingrix is a 2 dose series – 2<sup>nd</sup> shot to be given within 2-6 months after first dose.

Components of Shingrix: sucrose, NaCl, dioleoyl phosphatidylcholine (DOPC), potassium dihydrogen phosphate, cholesterol, sodium dihydrogen phosphate dihydrate, disodium phosphate anhydrous, dipotassium phosphate, polysorbate 80

I have been given the Centers for Disease Control and Prevention Vaccine Information Sheet. 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 shingles 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.

Patient Signature:

Date:

Printed name of above:

## FOR CLINIC USE ONLY

Vaccine	Manufacturer	VIS Date	Lot#	Exp Date	Site/Route	Dosage Vol
Shingrix	GSK	02/04/22			LD IM RD IM	0.5 mL
Immunizer Signature:				Admin Date:		

For office use only: \_\_\_\_\_ Billed \_\_\_\_\_ Scanned \_\_\_\_\_ PIERS \_\_\_\_\_ faxed office