Shingles Vaccination Consent Form and Record

Must be 50 years of age or older

Must remain in pharmacy for 10 minutes after injection

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

PERSONAL INFORMATION

NAME:

DATE OF BIRTH: PHONE:

☐ FEMALE ☐ MALE AGE:

ADDRESS:

FAMILY DOCTOR:

ALLERGIES/MEDICAL ALERT:

SCREENING QUESTIONS:

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

Note: If you answered YES to questions 1through 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 – 2nd 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* ____ *PA SIIS*