



### **Shingles Vaccine Administration Consent Form**

I have been given the opportunity to ask questions about the vaccine listed below and my questions were answered to my satisfaction. I have received the appropriate CDC Vaccine Information Statement (VIS) and have read the information or had it read to me. I have received all the information I need to give this informed consent. I have never had a history of hypersensitivity or a life threatening allergic reaction to gelatin, neomycin or to any other component of the vaccine. I understand any individual age 50 or older should receive this vaccine.

I understand the benefits, risks and contraindications to this vaccine. I understand, as with all medical treatments, there is no guarantee that I will become immune. I am not immunosuppressed, on hemodialysis, breastfeeding, or pregnant. I am not taking high dose corticosteroids or other immunosuppressive therapy. I do not have active tuberculosis. I will inform my health care provider if I have any current illness, infection or elevated temperature. I understand I may need to postpone the vaccination until I have recovered. I will inform my health care provider if I have received a vaccine or injection recently.

I understand that vaccines, like any medication, can cause mild side effects including soreness/redness at the injection site, fever, headache and body aches. Other reported side effects include bruising, itching at the injection site, diarrhea, runny nose, or rash. I understand that vaccines can in rare instances cause complications, including infection, allergic reaction and death. I also, understand that the chance of serious harm is very rare and that these vaccinations are FDA approved. I agree to accept this risk to decrease my chances of contracting a serious preventable disease. I understand to seek medical attention immediately if I have any difficulty breathing, swelling of the lips, wheezing, hoarseness, fast heart beat, hives, dizziness or swelling of the throat.

#### **Vaccine to be administered: Shingles (VIS 10/06/09)**

#### INFORMATION CONCERNING PERSON TO RECEIVE SHINGLES VACCINE:

NAME (please print)

DATE OF BIRTH

AGE

PHONE NUMBER

ADDRESS

CITY

STATE

ZIP

DO YOU HAVE ALLERGIES TO:  Gelatin  Neomycin ARE YOU PREGNANT?  Yes  No

HAVE YOU HAD ANY OTHER VACCINES IN THE LAST 4 WEEKS?  Yes  No

ARE YOU TAKING HIGH DOSE CORTICOSTEROIDS OR OTHER IMMUNOSUPPRESSIVE THERAPY?  Yes  No

DO YOU CURRENTLY HAVE ANY ILLNESS, INFECTION, OR ELEVATED TEMPERATURE?  Yes  No

NAME & ADDRESS OF FAMILY PHYSICIAN

#### CONSENT:

*I have read the above information and have had an opportunity to ask questions. I understand the benefits and risks of the shingles vaccination as described. I request that the vaccine be given to me or to the person named below for whom I am authorized to sign.*



SIGNATURE OF PERSON RECEIVING or AUTHORIZING VACCINE

DATE

**Vaccination Information (*office use only*)**

Merck Zostavax Lot #: \_\_\_\_\_ Exp. \_\_/\_\_/\_\_ Dose: 0.65mL Admin. Site: R L Arm Subcutaneously

Signature & Title of Vaccine Administrator: \_\_\_\_\_ Date Administered: \_\_\_\_\_