

Pneumococcal (PCV13) Consent Form & Vaccine Administration Record

Pneumonia - Pneumonia is inflamed lung tissue and can be caused by many types of germs. Symptoms of pneumonia caused by bacterial germs include a combination of high fever, cough with thick greenish or rust-colored mucus, shortness of breath, rapid breathing, sharp chest pain that is worse with deep breaths, abdominal pain, and severe fatigue. In high-risk groups, pneumonia could lead to further problems and even death.

The Vaccine - The pneumococcal conjugate vaccine (PCV) protects against 13 types of pneumococcal bacteria, including the types that cause meningitis and bacteremia. An injection of PCV will NOT give you pneumonia. The vaccine is made from a dead virus. We recommend that you remain on site for up to 15 minutes following the injection to monitor for possible vaccine reactions. The vaccine should be taken only one time, but a 5-year booster is recommended in some cases.

Risks and Possible Side Effects - Side effects of PCV are generally mild in adults. These reactions include pain and redness where the shot was given. These symptoms may last up to 48 hours. An immediate reaction resulting from an allergy to a vaccine component rarely occurs after a PCV vaccination.

Special Precautions - Children, pregnant women, and persons with a serious illness should consult their physician before receiving the pneumococcal vaccine.

- Persons who are allergic to latex should notify the pharmacist prior to receiving this vaccine.
- DO NOT receive this vaccine if you have an active infection.

□ *I hereby authorize the Pharmacy to bill Medicare Part B on my*

furnished to me by the pharmacy. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid

benefits payable for related services.

behalf. I request that payment of authorized Medicare benefits be made to the pharmacy for the **Pneumococcal vaccine and its administration** as

Services (CMS) and its agents any information needed to determine these

- DO NOT receive this vaccine if you are a Hodgkin's disease patient and it will be fewer than 10 days prior to or during treatment with immunosuppressive drugs or radiation.
- DO NOT receive this vaccine if you have had a serious reaction to PPV in the past.

INFORMATION CONCERNING PERSON TO RECEIVE PNEUMOCOCCAL VACCINE:

Please check one:	UN BELUW.	Va	ccination Information (office	use only)
MEDICARE RECIPIENTS PLEASE COMPLETE THE SECTION	ON DELOW!	<u> </u>		
\underline{X} SIGNATURE OF PERSON RECEIVING or AUTHO	RIZING VACCINE		DATE	
CONSENT: I have read the above information and have had described. I request that the vaccine be given to				al vaccine as
NAME & ADDRESS OF FAMILY PHYSICIAN				
HAVE YOU RECEIVED A PNEUMONIA	VACCINE IN THE LA	AST 5 YEARS?	□ Yes □ No	
ARE YOU CURRENTLY RECEIVING TREATMENT FOR HODGKIN'S DISEASE? □ Yes □ No				
DO YOU HAVE ALLERGIES TO: □ Diph	ntheria Vaccine □ Pne	umococcal vaccine	ARE YOU PREGNANT? □ Yes	s □ No
ADDRESS	CITY	STATE	ZIP	
NAME (please print)	DATE OF BIRTH	AGE	PHONE NUMBER	

PNEUMOVAX 23 Lot #:

Amount Paid:

IM Administration Site: R L Arm

Dose: 0.5mL

Signature & Title of Vaccine Administrator:

Date Administered:



 \Box I hereby attest that as of the date indicated above, I am <u>not</u> enrolled in *Medicare Part B*.