

PNEUMOCOCCAL VACCINE (PNEUMONIA VACCINE) CONSENT FORM

Before agreeing to receive the above vaccine, please take time to answer the following questions and read the following information:

- 1) Have you had a pneumonia shot within the last 5 years? **YES / NO (circle)**
 - 2) Are you 65 years or older? **YES / NO (circle)**
 - 3) If you are female, to the best of your knowledge are you currently pregnant or could there be a chance of you being pregnant? **YES / NO (circle)**
- If you have questions about the pneumonia vaccine, talk to your doctor or to the person administering your vaccine.
 - If you have any major medical conditions, please discuss and obtain advice from your treating provider.
 - Like all medicines, vaccines may have some side effects. Some redness, tenderness, discomfort or swelling is common at the injection site. The symptoms will usually subside within a few days.
 - It is not uncommon for some patients to develop a slight fever, muscle pains and generally feel a bit “unwell” for a few days after the vaccination.

PARTICIPANT INFORMATION AND CONSENT

LAST NAME: _____ FIRST NAME: _____

AGE: _____ PHONE #: _____

**I HAVE READ AND UNDERSTAND THIS INFORMATION. I CONSENT TO RECEIVING
THE PNEUMOCOCCAL VACCINE.**

SIGNATURE: _____ DATE: _____

FOR CLINIC USE ONLY:

Batch # / Exp. Date: _____

Given By: _____

Injection Site: _____

Signature: _____