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 60 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 9/11/06)**

_____ _____ _____
Name of Patient (Please Print Clearly) Date of Birth AGE

_____
Signature of Patient Date

_____
Signature of Parent/Legal Guardian Date

Please do not write below this line. **PHARMACY** Authorized personnel only

Dose 0.65 ml subcutaneous

Zostavax	_____	_____	_____	_____	SC	_____
Age 60+	Date	Manufacturer	Lot#, exp date	Injection Site	Route	Initials