Vaccine Trial Consent Form

Name (Please Print)	Date of Birth	Sex	County of Residence
Address	City	State	ZIP
Phone	For Persons Under 19 Years Old, Mother's Maiden Name		
Allergies?	Doctor's Name		
	Doctor's Address		
Emergency Contact	Contact Phone		

Please complete the questions below for yourself or the person receiving the vaccine.

☐ No ☐ Yes Are you currently sick with a fever?

☐ No ☐ Yes Have you ever had a life threatening allergy to any component (or part) of the flu or pneumonia vaccine?
If yes, please describe: _____

☐ No ☐ Yes Have you ever developed Guillain-Barre Syndrome within 6 weeks of receiving flu vaccine?

☐ No ☐ Yes Have you ever had a pneumonia shot?

☐ No ☐ Yes Are you a smoker or have a chronic medical condition such as asthma, heart or lung disease?
If yes, please describe: _____

☐ No ☐ Yes Have you ever had a severe life threatening allergy to eggs or egg products?

☐ No ☐ Yes Are you currently pregnant?

☐ No ☐ Yes Do you have a history of asthma or wheezing?

☐ No ☐ Yes Are you a child or adolescent receiving long-term aspirin therapy?

☐ No ☐ Yes Do you have a weakened immune system or have close contact with a person with an extremely weakened immune system who needs special care?

☐ No ☐ Yes Have you received any other vaccinations within the last 4 weeks?

☐ No ☐ Yes Have you taken an antiviral medication for the flu within the last 48 hours?

Vaccine Trial Consent

I have read, or had explained to me, the Vaccine Information Statemen t about **trial** vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the **trial** vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose. I have received a copy of the Patient Bill of Rights.

_____

Signature of Recipient (Parent or Guardian) Date

Area Below to Be Completed by Nurse

Pneumococcal Disease Vaccine

Administration Date _____

Administration Site ☐ Left Arm ☐ Right Arm ☐ Left Thigh ☐ Right Thigh

Manufacturer & Lot Number _____

VIS Date _____

Nurse Signature _____

Next Immunization Due: ☐ None Needed ☐ Other _____

Immunizer – White Provider – Yellow Patient – Pink