☐ Cy's ☐ Sinclair ☐ Tile ☐ Wanakah ☐ Kenmore ☐ Family

Pneumococcal 13-Valent Conjugate Vaccine Consent Form

(Patients 19 years and older)

Last Name: _____ First Name: _____ M.I.:_____

Date of Birth:___ / ___/___ Age: _____ Circle: Male / Female

Address:_____ Phone Number: (_____)_____-_____

City _____State: _____Zip: _____

Insurance Company: _____

ID#: _____ RXBIN:_____ RXGroup: _____ Person #: _____

Primary Care Physician to notify of this immunization: _____

Location/Phone # (if known): _____

CHECK ONE:

YES	NO	
☐	☐	I am 65(+) with no or an unknown history of prior receipt of PCV
☐	☐	I am 65(+) years old in need of a dose of PCV-13 and 12 months or more have passed since the PPSV-23 vaccine was received.
		I am 19 to 64 years old with no known history of prior receipt of PCV with at least one of the following conditions:
☐	☐	• Cigarette Smoker
☐	☐	• Chronic cardiovascular disease (eg. Congestive heart failure, cardiomyopathies)
☐	☐	• Chronic pulmonary disease (eg. Chronic obstructive pulmonary disease, emphysema, asthma)
☐	☐	• Diabetes, alcoholism or chronic liver disease (cirrhosis)
☐	☐	• Functional or anatomic asplenia (eg. Sickle cell disease, splenectomy)
☐	☐	• Immunocompromising condition (eg. HIV infection, congenital immunodeficiency, hematologic and solid tumors)
☐	☐	• Organ or bone marrow transplantation
☐	☐	• Chronic renal failure or nephrotic condition
☐	☐	• Candidate for or recipient of Cochlear implant

I am well, not sick, and without fever today. I do not have a history of a serious reaction after a previous dose of PCV or to a vaccine component. I have received a copy of the Vaccine Information Statement (VIS) about the pneumococcal polysaccharide vaccine, have read or have had explained to me the information contained there-in, and had a chance to ask questions about this vaccine and am satisfied with the responses. I understand the benefits and risks associated with receiving a vaccination. I understand that this vaccination is highly effective but does not guarantee immunity against any or all strains of pneumococcal infection. I request that the pneumococcal vaccination be administered to me. I understand that it is recommended to remain in the facility for 15 minutes after vaccination. I accept responsibility for seeking appropriate medical care for any problems associated with receiving this vaccine. I release the pharmacy and its employees from any responsibility or liability with regard to administration of the pneumococcal vaccination. I have had the opportunity to receive and understand the pharmacy's privacy policy with regard to health care information. I authorize payment of insurance benefits for services provided to me by the pharmacy to receive payment for such services provided to me. I understand that I will be responsible for any payment in full if my insurance company fails to cover this vaccine and administration for whatever reason. I authorize the pharmacy to notify my primary health care provider of the receipt of this vaccination.

☐ Yes ☐ No All immunizations will be posted on the New York State Immunization Information System (NYSIIS) Unless 'No' checked.

Signature of Recipient _____ **Date**_____

Vaccination name: _____

Manufacturer: _____Lot: _____ Site: LD / RD

Administered by: _____Date:___ /___/ ___ Time:____ : ____ AM/PM