

Adult Respiratory Syncytial Virus (RSV) Vaccine Consent Form

Cy's Sinclair Tile Wanakah Kenmore Family Medical Larwood Alden

Print Carefully:

Last Name First Name M/I Birth Date Age M/F

Street Address City Zip Code Phone Number

Screening:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Are you 60 years of age or older?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had any vaccines in the last 14 days?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any allergies to vaccines or vaccine components?
<input type="checkbox"/>	<input type="checkbox"/>	Do you feel sick today?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a fever?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a weakened immune system?

Do you have any of the following conditions that are associated with an increased risk for severe RSV disease? **Yes** **No**

- Lung disease (such as chronic obstructive pulmonary disease (COPD) and asthma)
- Cardiovascular diseases (such as congestive heart failure and coronary artery disease)
- Moderate or severe immune compromise
- Diabetes mellitus
- Neurological or neuromuscular conditions
- Kidney or Liver disorders
- Hematologic Disorders

Consent:

By signing below, I attest that I have received the RSV Vaccine Sheet (VIS) and have had the opportunity to ask questions. I understand the benefits and risks associated with receiving a vaccination. I request that the vaccine be administered to me, and it is recommended that I remain in the healthcare facility for 15 minutes after the vaccine. I authorize the pharmacy to notify my primary health care physician of the receipt.

By checking this box, I authorize the pharmacy to upload my immunization to NYSIIS (NYS Vaccine database)

Signature of Recipient _____ Date _____

Vaccination Name: _____ Manufacturer: _____

Lot: _____ Site: LD/RD Administered by: _____

Date: ____/____/____ Time: ____:____ AM/PM Signature: _____