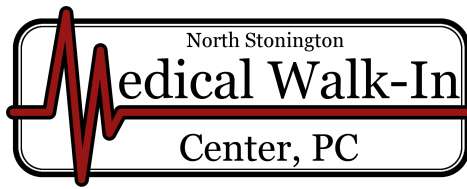


82 Norwich-Westerly Road  
North Stonington CT 06359



Phone: (860)599-2469  
Fax : (860)599-2830

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## **Pneumococcal Immunization Consent Form**

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ SSN: \_\_\_\_\_

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Are you allergic to eggs or Thimerosal? Yes / No

Have you ever had a serious reaction to a flu or pneumonia shot? Yes / No

Have you ever had Guillain Barre Syndrome? Yes / No

Have you ever received the pneumonia shot? Yes / No  
If yes, when? \_\_\_\_\_

Are you sick with a fever? Yes / No

Are you pregnant or nursing? Yes / No

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I have read, or had explained to me, the information sheet relating to the pneumococcal vaccination. I have been given the chance to ask questions and have been provided answers by this medical practice. I understand the benefits and risks of the vaccination as described in the information sheet provided.

I request the pneumococcal vaccine be given to me (or to the person 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 insurance claim.

\_\_\_\_\_  
Signature (or Parent/Guardian)

\_\_\_\_\_  
Date

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For office use only:

Injection site: Right Arm \_\_\_\_\_ Left Arm \_\_\_\_\_

Manufacturer: \_\_\_\_\_

Lot: \_\_\_\_\_ Expiration: \_\_\_\_\_

Medical staff initials: \_\_\_\_\_ Date: \_\_\_\_\_