82 Norwich-Westerly Road
North Stonington CT 06359

North Stonington Medical Walk-In Center, PC

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

Pneumococcal Immunization Consent Form

Name:_____ Date of Birth_____

Street Address:_____

City:_____ State:_____ Zip:_____

Telephone:_____ SSN:_____

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

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

For office use only:

Injection site: Right Arm_____ Left Arm_____

Manufacturer:_____

Lot:_____ Expiration:_____

Medical staff initials:_____ Date:_____