PARAMOUNT
URGENT CARE

www.paramounturgentcare.com

Visit Location: _____ **Phone Number:** _____

Visit Date: _____

PNEUMOCOCCAL VACCINE (PNEUMONIA VACCINE) CONSENT FORM

Before agreeing to receive the above vaccine, please take time to answer the following questions and read the following information:

1) Have you had a pneumonia shot within the last 5 years? **YES / NO (circle)**
2) Are you 65 years or older? **YES / NO (circle)**
3) If you are female, to the best of your knowledge are you currently pregnant or could there be a chance of you being pregnant? **YES / NO (circle)**

- If you have questions about the pneumonia vaccine, talk to your doctor or to the person administering your vaccine.
- If you have any major medical conditions, please discuss and obtain advice from your treating provider.
- Like all medicines, vaccines may have some side effects. Some redness, tenderness, discomfort or swelling is common at the injection site. The symptoms will usually subside within a few days.
- It is not uncommon for some patients to develop a slight fever, muscle pains and generally feel a bit "unwell" for a few days after the vaccination.

PARTICIPANT INFORMATION AND CONSENT

LAST NAME: _____ FIRST NAME: _____

DOB: _____ AGE: _____ PHONE #: _____

I HAVE READ AND UNDERSTAND THIS INFORMATION. I CONSENT TO RECEIVING THE PNEUMOCOCCAL VACCINE.

SIGNATURE: _____ DATE: _____

FOR CLINIC USE ONLY:

Batch # / Exp. Date: _____ Injection Site: _____

Given By: _____ Signature: _____

Provider: _____