



543 W. Main St. - New Britain, CT 06053 - (860) 225-6487
233 Main St. - New Britain, CT 06051 - (860) 356-3270

Pneumonia Vaccine Consent Form and Administration Record

Personal Information (PLEASE PRINT)

Name: _____ Date of Birth: _____ Sex: M F

Address: _____ City: _____

State: _____ Zipcode: _____ Phone Number: _____

Screening Checklist

	No	Yes	Unsure
1. Are you feeling significantly sick today? (ex: fever, nausea, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any allergies to medications, latex, or a vaccine component? allergen and reaction (ex: hives/anaphylaxis): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a <u>serious</u> reaction after receiving a vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had/currently have a neurological disorder, seizures, or GBS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you pregnant or breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you been vaccinated for pneumonia in the past? if yes, which vaccine: ___Pevnar13 ___Pneumovax23 ___Pevnar20 ___Other/Unsure approx. date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I have read or have had explained to me the Vaccine Information Statement and have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent/guardian). [VIS Edition Date 2/4/22]

Signature _____ Date _____

[if guardian, relationship to patient] _____

Vaccine Manufacturer: _____

Lot #: _____ Expiration: _____ Dose: 0.5 mL Route: IM

Date Administered: _____ Location: Left Deltoid / Right Deltoid

Immunizer: _____ Title: Intern / Pharmacist / Nurse



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Insurance Information

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Insurance Company: _____
[used for insurance billing purposes only]

Cardholder Name: _____ Relationship: _____

Cardholder ID: _____ Rx BIN #: _____

PCN: _____ Rx Group #: _____