PHARMACY COCOPY

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

Respiratory Syncytial Virus (RSV)
Vaccine Consent Form and Administration Record

Personal Information (PLEASE PRINT)

Name: ______________________ Date of Birth: ____________ Sex: M F

Address: ______________________________ City: ________________

State: ________ Zipcode: ___________ Phone Number: ________________

Email: __________________________________

Screening Checklist (ADULTS & CHILDREN)	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to a component of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated received a vaccine in the past 2 weeks?	☐	☐	☐
4. Is the person to be vaccinated pregnant or breastfeeding?	☐	☐	☐

I have read or have had explained to me the Vaccine Information Statement about RSV and the RSV vaccine. I have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine 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 7/24/23]*

Patient/Guardian Signature ______________________________ Date ________

[if guardian, relationship to patient] ______________________

Vaccine Manufacturer: Pfizer RSV Vaccine ABRYSVO

Lot #: ________ Expiration: ____________

Dose: 0.5 mL Route: IM

Date Administered: ________________ Location: Left Deltoid / Right Deltoid

Immunizer: ____________________ Title: Intern / Pharmacist / Nurse

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

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 #: _________________________

If no insurance, cost to patient is* **$_____