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

Shingles 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	Don't Know
1. Are you feeling significantly sick today? *(ex: fever, nausea, etc.)*	☐	☐	☐
2. Do you have any allergies to medications, latex, or a vaccine component? *allergen and reaction (ex: hives/anaphylaxis):* _____	☐	☐	☐
3. Have you had Shingles in the past?	☐	☐	☐
4. Have you ever had a serious reaction after receiving a vaccine?	☐	☐	☐
5. Are you 50 years of age or older?	☐	☐	☐

I have read or have had explained to me the Vaccine Information Statement about Shingles and the SHINGRIX 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 Shingles 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 2/4/22]*

Patient/Guardian Signature _____ Date _____

[if guardian, relationship to patient] _____

Vaccine Manufacturer: GSK Zoster Vaccine Recombinant, Adjuvanted- SHINGRIX
Lot #: _____ Expiration: _____
Dose: 0.5 mL Route: IM

Date Administered: _____ Location: Left Deltoid / Right Deltoid

Immunizer: _____ Title: Intern / Pharmacist

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SHINGRIX Vaccine Administration Record

Name: _____ Date of Birth: _____

Phone #: _____

Vaccine Manufacturer:
GSK Zoster Vaccine Recombinant, Adjuvanted
SHINGRIX

Dose: 0.5 mL Route: IM

1st Dose

Administration Date: _____ Location: Left Deltoid / Right Deltoid

Lot #: _____ Expiration: _____

Immunizer Initials: _____

2nd Dose

second dose due 2-6 months after initial dose to complete vaccine series

Administration Date: _____ Location: Left Deltoid / Right Deltoid

Lot #: _____ Expiration: _____

Immunizer Initials: _____

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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 #: _____

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