DR. GARY BIRDSALL
MEDICAL CLINIC, LLC

INFORMED CONSENT FORM FOR PNEUMOCOCCAL VACCINE

NAME: _____ **DOB:** _____

I. CONTRAINDICATIONS

		YES	NO
A.	Hypersensitivity to any component of the vaccine	( )	( )
B.	Currently ill with acute respiratory illness, febrile illness, or other activit infections or illnesses	( )	( )

***** A positive response to any of the above requires a consultation with a physician prior to administration of the vaccine.**

II. CONSENT

I consent to take the Pneumococcal Vaccination. I have read or have had explained to me the information about pneumococcal infection and vaccine, including the benefits and risks of the pneumococcal vaccine.

_____ _____

Witness **Patient Signature**

Date: _____

TO BE COMPLETED BY NURSE:

Any contraindications _____

Date and Time Administered _____

Administered by _____

Site of Injection _____

Manufacturer _____

Lot # _____

Adverse Reactions Notes: _____

_____