

## IMMUNIZATION CONSENT FORM

The Center for Disease Control (CDC) recommends the following immunizations for older adults unless clinically contraindicated due to known serious allergy (such as angioedema) or other acute or chronic conditions as recommended by the CDC.

### Influenza (flu vaccine)

Residents of nursing homes or chronic care facilities, regardless of age, should receive the flu vaccine annually. A High dose or enhanced formulation is preferred.

### Pneumococcus (pneumonia vaccine) <sup>1</sup>

Previously unvaccinated adults ≥ 65 years of age: PCV 13 first, then PPSV 23 one year later.

Previously received PPSV 23 at age ≥ 65: PCV 13 at least one year after receipt of PPSV 23.

Previously received PPSV 23 before age 65 years who are now age ≥ 65: PCV 13 at least one year after receipt of PPSV 23, then PPSV 23 after five years of previous vaccination (no earlier than one year of PCV 13).

<sup>1</sup> Dosing interval may vary for special patient populations per CDC guidelines.

### Tetanus/diphtheria/pertussis (tetanus - “lockjaw”, pertussis - “whooping cough” and diphtheria vaccine)

Tdap x1 dose for adults

Td booster every 10 years

Complete vaccine series is indicated for older adults with uncertain vaccine history or with fewer than three recorded doses.

### Shingrix (shingles vaccine)

Adults ≥ 50 years old: a 2-dose series at 0 and 2-6 months regardless of history of herpes zoster.

Revaccinate if already received Zostavax in the past.

I have received a copy of the most current Vaccination Information Sheet (VIS) as published by the CDC. I have read or have had explained to me information on the above vaccines including:

- Description of the vaccine and the disease the vaccine is intended to prevent
- Benefits for receiving the vaccine
- Risks and possible side effects of each vaccine
- Any special precautions

I have had a chance to ask questions that were answered to my satisfaction. I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim with respect to the vaccines described herein.

**YES** - I understand the benefits and risks associated with the above listed vaccines and I **consent** to receiving the following listed vaccines as deemed appropriate by my care provider.

Please check the vaccines that you wish to receive:

- Influenza (flu) vaccine**       **Pneumococcus (pneumonia) vaccine**  
 **Shingrix (shingles) vaccine**     **Tetanus/diphtheria/pertussis vaccine**

**NO** - I understand the benefits and risks associated with the above listed vaccines and I **do not consent** to receiving any of the above-listed vaccines.

\_\_\_\_\_  
Resident’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Resident’s Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time