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**Pneumococcal Vaccination Consent Form**

**Resident Information**

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_/\_\_\_/\_\_\_\_\_

**Screening for pneumococcal vaccine eligibility**

1. Have you ever had a life-threatening reaction to the pneumococcal vaccine? □ Yes □ No

2. Are you moderately or severely ill today? □ Yes □ No

*If yes to question 1 then* ***DO NOT*** *vaccinate with pneumococcal vaccine. If yes to question 2, vaccinate when resident has recovered.*

I have read or had explained to me the Vaccination Information Statement about pneumococcal vaccination and I understand the benefits and risks of pneumococcal vaccination. I request that the pneumococcal vaccination be given to me (or the person named above for whom I am authorized to make this request).

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**To be completed by person administering vaccine**

Today’s Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_ Age of patient: \_\_\_\_\_\_\_\_\_\_\_

Site of Injection: □ R □ L Administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lot #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Record Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Room Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Pneumococcal Vaccination Declination Form**

**Resident Information**

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_/\_\_\_/\_\_\_\_\_

**I acknowledge that I am aware of the following facts:**

* Pneumococcal disease is a respiratory disease that can cause life-threatening infections in the lungs (pneumonia), blood (bacteremia), and brain (meningitis).
* Pneumococcal disease kills more people in the United States each year than all vaccine preventable diseases combined and highest mortality occurs among the elderly and patients with underlying medical conditions.
* I understand that the pneumococcal vaccine does not contain live bacteria so I cannot get pneumococcal disease from the vaccine.
* I understand that pneumococcal vaccination is recommended by the Centers for Disease Control and Prevention for adults 19 years of age and older with certain medical conditions and for people 65 years of age and older because they are at greater risk for pneumococcal infection.
* I understand the consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact.

***Knowing these facts, I choose to decline the pneumococcal vaccination at this time.*** I may change my mind and accept vaccination later, if vaccine is available.

**I *decline vaccination***for the following reason(s). Please check all that apply.

□ I am up-to-date on my pneumococcal vaccination (verified).

□ I believe I will get pneumococcal disease if I get the vaccine.

□ I do not like needles.

□ My religious beliefs prohibit vaccination. □ I have an allergy or medical contraindication to receiving the pneumococcal vaccine.

□ Other reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read or had explained to me this information and fully understand the information on this declination form. I am declining the opportunity to receive the pneumococcal vaccine (or the person named above for whom I am authorized to make this decision).

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_