Shingles Vaccine - Shingrix®
Consent for Immunization

Date (D/M/Y):	Name (Last, First):	
Provincial Health Number (PHN):		
Address:	City:	Postal Code:
Home Phone:	Mobile:	Email:
Date of Birth (D/M/Y):	Age:	☐ Male ☐ Female ☐ Transgender

Shingles Vaccine Questionnaire

Do you or anyone in your close contact have any Covid-19 symptoms? ☐ Yes ☐ No ☐ Not sure

Have you had any Shingles vaccine before? ☐ Yes ☐ No ☐ Not sure

Have you ever had any reaction to any vaccine? ☐ Yes ☐ No ☐ Not sure

Are you or do you think you might be pregnant? ☐ Yes ☐ No ☐ Not sure

Do you qualify for the Shingles' publicly funded vaccine?

☐ As of February 1, 2021, Shingrix® vaccine coverage is available at no cost to First Nations Elders who are 65 years old and older.

Do you have any food/drug/vaccine allergies? _____

Consent Given by Patient/Agent

I, the undersigned client, parent or guardian, have read or had explained to me information about the Shingles vaccine (Shingrix ®). I have had the chance to ask questions, and answers were given to my satisfaction. I understand the risks and benefits of receiving the Shingles vaccine. I agree to wait in the pharmacy for 15 minutes after receiving the vaccine.

PUT YOUR APPOINTMENT DATE HERE

_____ _____ _____

Patient/Agent Name (& Relationship) Patient/Agent Signature Date Signed (D/M/Y)

Pharmacy Use Only

Pharmacist Signature: _____	Name of Viccine: **Shingrix ®**
License # : _____	Vaccine Lot#: _____
Date of Immunization: _____ ☐ Same as above	Vaccine Expiry Date (MM/YYYY): _____
Time of Immunization: _____	Site: Arm ☐ Left ☐ Right