Zostavax, Zoster Vaccine Live
McElroy Pharmacy Immunization Consent Form

Name:_____ **DOB:**_____

Primary Physician:_____

Please circle answers to questions 1-8:

1. Are you age 60 or over?	No	Yes
2. Do you have an illness today with a fever more than 101°F?	No	Yes
3. Have you ever had a severe allergic reaction (anaphylaxis) to gelatin, neomycin, or to any vaccine? Which vaccine? _____	No	Yes
4. Do you have a weakened immune system due to HIV/AIDS, another disease that affects the immune system, or cancer treatment such as radiation or chemotherapy?	No	Yes
5. Do you take immunosuppressive therapy or oral steroids?	No	Yes
6. Do you have a history of cancer affecting the bone marrow or lymphatic system, such as leukemia or lymphoma?	No	Yes
7. Do you have active tuberculosis (TB)?	No	Yes
8. Are you in close contact with someone who has a weakened immune system, has not had chickenpox, or has not been vaccinated against chickenpox?	No	Yes

Stop. Do not write below this line.

□ **Vaccine administered**: ZOSTAVAX® Zoster Vaccine Live (Oka/MERCK)
Dose: 0.65 ml Route: SQ Site: (Left / Right) arm
Lot #:_____ Exp:_____

Administered by:_____ Date:_____
McElroy Pharmacy P:717-626-2222 F:717-626-7920

---Please Update Vaccination Records Accordingly! Thank You---