ZOSTER VACCINE

ADMINISTRATION RECORD

I have read or have had explained to me the information in the Vaccine Information Statement about zoster (shingles) vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the zoster vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request.

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT)			
Name: LAST:	FIRST:		MIDDLE INITIAL:
Address:	Phone:	Birthdate:	M/F WT. Age:
City:	State:	ZIP:	County:
Allergies:			
Physician Name:	Address:		

FOR MEDICARE RECIPIENTS: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts the assignment.

SEE ATTACHED COPY OF MEDICARE CARD IF MEDICARE ELIGIBLE

SIGNATURE AUTHORIZING VACCINATION; of person to receive vaccine or person authorized to make request (parent or guardian) for vaccination **X**		DATE:
Patient Signature above and Vaccinator signature below also indicates patient receipt of the current Zoster Vaccine Information Statement on date signed.	VIS DATE:	CHRONIC ILLNESS [ ] YES [ ] NO

DO NOT WRITE BELOW THIS LINE (CLINIC/OFFICE USE ONLY)

****

FOR CLINIC/OFFICE USE ONLY

PHARMACY/CLINIC NAME:	
ADDRESS:	
MEDICARE PIN:	
DATE VACCINE ADMINISTERED:	
VACCINE NAME & MANUFACTURER:	Shingrix/GlaxoSmithKline
VACCINE LOT NUMBER:	
SITE OF INJECTION / NEEDLE GAUGE / LENGTH	L Arm R Arm / 25G 1in 25G 5/8in Other
STRENGTH/DOSE GIVEN & ROUTE Other Notes	0.5 mL IM Notes:
SIGNATURE / TITLE OF VACCINE ADMINISTRATOR:	
Other Medications Administered (e.g., epinephrine, etc.)	

PAYMENT SOURCE:

[ ] CASH [ ] CHECK [ ] * BILL MEDICARE OTHER _____

* IF MEDICARE ELIGIBLE THE MEDICARE CARD IS REQUIRED.