

Respiratory Syncytial Virus (RSV) Vaccine Consent Form

Patient Information

Full Name: Print		Date of Birth:	
Responsible Party: Print		Relationship	
Consent by phone Nurse Name			Date
Consent given:	Yes	No	Nurse Signature

Health Screening Questions

1. Are you feeling sick today?	Yes	No
2. Have you ever had a severe allergic reaction to a vaccine or any of its components?	Yes	No
3. Have you ever had an allergic reaction to latex?	Yes	No
4. Have you ever been diagnosed with an immune system disorder or are you taking any immunosuppressive medications?	Yes	No
5. Have you received any vaccines in the past 14 days?	Yes	No
6. Have you ever been diagnosed with Guillain-Barre' Syndrome (GBS)?	Yes	No

Vaccine Information

Vaccine Name:	Arexvy	Manufacturer:	GlaxoSmithKline
Lot Number:		Expiration Date:	
Site of Injection:	Left Deltoid____Right Deltoid____	Dose Administered:	0.5 ml____ Other____
Name/Signature of Vaccinator		Date:	

Consent for Vaccination

I have read, or had explained to me, the information about the RSV vaccine. I understand the purpose, benefits, and potential risks of the vaccination. I have had the opportunity to ask questions, and they were answered to my satisfaction. I consent to the administration of the RSV vaccine to myself (or the person named above for whom I am authorized to give consent.)

Signature of Patient(or Guardian):		Date:	
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