PNUEMOCOCCAL VACCINE CONSENT

Indication and Usage
PNU-IMUNE 23 is indicated for immunization against pneumococcal disease caused by those pneumococcal types included on the vaccine.

ADULTS

1. All adults 65 or older with emphasis on immunization of the older adult while in good health.
2. Immunocompetent adults who are at increased risk of pneumococcal disease or its complications because of chronic illness (e.g. Cardiovascular or pulmonary disease, diabetes mellitus alcoholism, cirrhosis, or cerebrospinal fluid leaks).
3. Innunocompromised adults at increased risk of pneumococcal disease or its complication.

CHILDREN

1. Children ofver 2 years of age or older with chronic illnesses specifically associated with increased risk of pneumococcal disease or its complications.

CONTRAINDICATIONS
HYPERSENSITIVITY TO ANY COPONENT OF THE VACCINE, INCLUDING THIMEROSAL, A MERCURY DERIVATIVE, IS CONTRAINDICATION TO THE USE OF THE PRODUCT.

THE OCCURUNCE OF ANY TYPE OF NEUROLOGICAL SYMPTOMS OR SIGNS FOLLOWING ADMINISTRATION OF THIS PRODUCT IS A CONTRAINDICATION TO FURTHER USE.

THE VACCINE SHOULD NOT BE ADMINISTERED TO PERSONS WITH ACUTE FEBRILE ILLNESS UNTIL THEIR TEMPORARY SYMPTOMS AND/OR SIGNS HAVE ABATED.

ADVERSE REACTIONS

1. Pneumococcal Vaccine is associated with a relatively low incidence of adverse reactions. The adverse reactivity observed in clinical studies was of short duration and not serious.
2. Low grade fever less than 100˚F and mild myalgia occur occasionally and are usually confined to the 24-hour period following immunization.
3. 72% of case study of individuals experienced local reaction characterized by soreness at the injection site.

I have read or have had explained to me the information on this form about pneumonia vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of pneumonia vaccine and request that the vaccine be given to me or to the person named below for whom I am authorized to make this request.

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (Please Print)		
Name Last First MI	Birth date	Age
Address Street	Telephone	County
City State		Zip
Signature of person to receive vaccine or person authorized to make this request		

FOR CLINIC USE
Clinic Identification
Date Vaccinated
Manf. And Lot No.
Site of Injection

Medicare #: ______________________________