Courtyard Surgery
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West Sussex
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SHINGLES VACCINATION CONSENT FORM 2014-15

Name:	**Date of Birth:**
Address:	
Telephone number:	
GP:	

Have you previously suffered any hypersensitivity to a constituent of the vaccine?	Yes		No	
Are you allergic to any antibiotics? ie Neomycin	Yes		No	
If yes, please name the anti-biotic:				
Have you been given information regarding potential side effects and health advice?	Yes		No	
Are you taking any immunosuppressant drugs?	Yes		No	
Are undergoing, or have you undergone, any kind of immunosuppressant therapy in the last 6 months?	Yes		No	
Are you in contact with anyone who is immunosuppressed?	Yes		No	
Are you Asplenic or have any splenic dysfunction?	Yes		No	
Are you or could you be pregnant?	Yes		No	

Do you consent for some of your medical information to be shared with Courtyard Surgery, Horsham?	Yes		No	

Do you consent to be given a Shingles vaccination?	Yes		No	

Signature: _____ **Date:** _____

Name if signing of behalf of patient: _____ **Relationship to patient:** _____

☐ **Verbal consent given by** _____ **if consent is signed by manager**