



Respiratory Syncytial Virus (RSV) Vaccine Consent Form

Last Name: _____

First Name: _____

Date of Birth: ____/____/____ Age: ____
Year Month Day

Gender: ☐ Male ☐ Female ☐ Other

Health Card Number: _____

Address: _____

Personal phone number: (_____) _____

Please answer the following questions:

Have you received a dose of any RSV vaccine?	☐ Yes	☐ No
Have you ever had a bad reaction to a vaccine before?	☐ Yes	☐ No
Do you have any medical conditions that the nurse should be aware of?	☐ Yes	☐ No
Do you have any serious allergies (other than environmental)?	☐ Yes	☐ No

PLEASE SIGN THIS AREA IF YOU WISH TO BE VACCINATED

I have read or had explained to me the information about RSV vaccine. I have had a chance to ask questions which have been answered to my satisfaction.

- ☐ If signing for someone other than myself, I confirm that I have the legal authority to provide consent for the individual that is to receive the RSV vaccine.
- ☐ If Applicable: I consent to having my retirement residence receive a copy of this completed form.

OR

Consent – Self signature

Consent – Substitute Decision Maker

Name of person signing (please print)

Date

FOR OFFICE USE ONLY

Health Status Reviewed: ☐ Yes ☐ No

The person named above received the RSV vaccine as follows:

Dosage: ☐ 0.5 ml

Vaccine Name: _____

Lot # _____

Expiry Date: _____

Date: ____/____/____
Year Month Day

Time: _____

R / L Deltoid Intramuscularly

Comments:

Nurse's Signature and Designation: _____