St Mary's Surgery, Ely

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SHINGLES VACCINATION CONSENT FORM

Name: _____

D.O.B. _____

Important Medical Information

Do you feel well today?	Yes ☐ No ☐
Are you allergic to Gentamicin or Gelatin?	Yes ☐ No ☐
Do you have any other allergies?	Yes ☐ No ☐
Do you have active untreated tuberculosis?	Yes ☐ No ☐
Do you have active infection with shingles?	Yes ☐ No ☐
Do you have post shingles nerve pain (post-herpetic neuralgia)?	Yes ☐ No ☐
Are you within 14 days of starting immunosuppressive therapy?	Yes ☐ No ☐
Are you taking **any** medication which may suppress your immune system?	Yes ☐ No ☐
Have you had >40 mgs **prednisolone** tablets for more than 7 days in the last 3m?	Yes ☐ No ☐
Have you had >20mgs **prednisolone** per day for more than 14 days in the last 3 m?	Yes ☐ No ☐
Have you had **methotrexate** >25mg per week for 3m?	Yes ☐ No
Have you had **azathioprine** >3.0mg/kg/day for 3m?	Yes ☐ No ☐
Have you had **6- mercaptoptopurine** >1.5mg/kg/day for 3m?	Yes ☐ No ☐
Has you any condition which may affect your immune system such as leukemia, lymphoma, myeloma, organ transplant?	Yes ☐ No ☐

If you have answered yes to any of the above please give details:

CONSENT

I consent to receiving a shingles vaccination.

Signature

Date