

Fort Bayard Medical Center
PNEUMOCOCCAL IMMUNIZATION INFORMED CONSENT

I hereby give Fort Bayard Medical Center permission to administer a **pneumococcal vaccination**. I understand that this immunization is to be given only one time. To the best of my knowledge, I have not received a pneumococcal vaccination. I have been instructed that as a result of this vaccination, I may experience some side effects such as:

- Slight discomfort
- Soreness of the arm
- Redness of the arm
- Slight fever (occasionally)
- Muscle aches (occasionally)
- Joint aches (rarely)
- Rash (rarely)

____/____/____
Date

Signature—Resident

____/____/____
Date

Signature—Responsible Party
(If applicable)

____/____/____
Date

Signature--Witness

Recommended per Dr.'s Order

____/____/____
Date

Resident's Name: _____ Admission No: _____