Deansgrange Medical Centre
2 Clonkeen Road, Blackrock,
Co. Dublin.

Varicella Zoster (Shingles) Immunisation Consent Form

Patient's name & DOB: (place addressograph here)

Parent/Guardian's Name (if applicable): _____

Vaccine Lot Number: **Expiry date:**

I have been fully informed about the above vaccine and which disease it provides protection against, the possible side effects, when they might occur and how they should be treated. I confirm by signing this form that I'm authorising consent on behalf of myself or the above named child. I consent for these vaccines to be administered to me/my child.

Patient or Parent/Legal Guardian signature: _____

Date: _____

1st visit administered by: _____ **Date: _____**

2nd visit administered by: _____ **Date: _____**