

**CONSENT FOR ZOSTAVAX  
VACCINE**

I, \_\_\_\_\_ (Print Your Name), consent to receiving the Zostavax vaccine and I have had the opportunity to ask questions and I understand the benefits and risks of the vaccine. I understand that there is no guarantee that I will not develop shingles or its associated complications or that I will not experience adverse side effects from the vaccine. I agree to hold Robert Sadaty M.D. or any staff member working with or for Robert Sadaty M.D.P.A, harmless from any and all adverse consequences with respect to administration of the vaccine. A copy of the drug insert is available to me upon request. I have read the Zostavax fact sheet.

X \_\_\_\_\_ (Patient's Signature)

Date: 09/14/2009