☐ Cy's ☐ Sinclair ☐ Tile ☐ Wanakah ☐ Family ☐ Kenmore

_____ Pt Chart _____ Impact SIIS

Td/Tdap Vaccine Consent Form

Must be 7 years of age or older (patients 7-12 must have a prescription)
Must remain in pharmacy for 10 minutes after injection

PERSONAL INFORMATION

Patient Name _____ DOB _____

Patient Phone:
( )

Date of Birth: Age:
/ /

☐ Female ☐ Male

County:

Family Doctor:

Medical/Commercial Insurance ID:

SCREENING QUESTIONS

Are you currently sick with a fever?	☐ Yes ☐ No
Do you have a severe (life-threatening) allergy to latex or any component (or part) of this vaccine, including aluminum phosphate, formaldehyde, glutaraldehyde, 2-phenoxyethanol, sodium chloride, and polysorbate?	☐ Yes ☐ No
Have you ever had a severe (life-threatening) allergic reaction to a previous dose of any vaccine?	☐ Yes ☐ No
Have you ever developed Guillain-Barre Syndrome within 6 weeks of receiving a vaccine, or ever had Guillain-Barre Syndrome?	☐ Yes ☐ No
Have you had a seizure or a brain or other nervous system problem?	☐ Yes ☐ No

Please remain in the pharmacy for 10 minutes following the vaccination. If you leave, you are doing so against medical advice.

I have read or have had explained to me the information in the Vaccine Information Statement about tetanus, diphtheria,and/or pertussis (Td/Tdap vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of tetanus, diphtheria,and/or pertussis (Td/Tdap) vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request. I waive and release all claims I, or anyone claiming by or through me, now have or may hereafter acquire against the dispensing pharmacies, and their respective directors, officers, employees and agents for any damage or injuries if I, or the person named below for whom I am authorized to make this request, contact tetanus, diphtheria, pertussis, other diseases, or suffer any other adverse reactions following administration of thisTd/Tdap vaccine. I understand that I may be held responsible for charges that are not covered by my insurance. I understand that if I do not provide the proper insurance information I may also be held responsible for charges. For Medicare Recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party that accepts assignment.

SIGN

_____ _____

SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE THE REQUEST (PARENT OR GUARDIAN)___ DATE

---FOR CLINICAL USE ONLY---

IMMUNIZER	TITLE	DATE OF IMMUNIZATION	VIS DATE	SITE OF INJECTION ☐LA/IM ☐RA/IM

VACCINE / MFG / DOSAGE:			LOT #	EXP. DATE
☐ Adacel/Sanofi/0.5ml Tdap (10-64 YO)	☐ Boostrix/GSK/0.5ml Tdap (10 or older	☐ Tenevac/Sanofi/0.5ml Rd (7 or older)		

INSURANCE	STORE
☐ Medicare ☐ Rx Coverage ☐ Major Med ☐ Cash _____	

Updated August 2020