



PREVENT. PROMOTE. PROTECT.

Tdap (Tetanus, Diphtheria and Acellular Pertussis)

VACCINE CONSENT FORM

Section 1: Patient Information (Please PRINT)

Name:		Birthdate:	
Age:	Race:	Gender: Male	Female
Street:	Zip:	Phone #:	
Parent/Guardian's Name:			

Section 2: Screening

When was the last time your child received a Tetanus (Td/Dtap/Dt/Tdap) shot?

_____ / _____ / _____ UNKNOWN
 Month / Day / Year

Is this child sick today? yes no

Does the child have allergies to medications/vaccines/foods? yes no

 If yes, what? _____

Has the child ever had a serious reaction to any vaccines?yes no

Consent for Child's vaccination:

I received a copy & have read the Hamilton County Public Health Notice of Privacy Practice (www.hamiltoncountyhealth.org) and the Tdap Vaccine Information Statement (available @ www.immunize.org). I believe I understand the benefits & risks of the vaccine. I give my consent for this record to be released to health care providers, schools, community & state immunization registry databases and others as is necessary.

I give consent to Hamilton County Public Health and its staff to vaccinate my child named on this form with the Tdap vaccine.

Signature of Parent/Guardian: _____ Date: _____

Vaccine lot number: _____ Date: _____

Signature of Vaccine Administrator: _____

Injection site: RD LD RT LT