TETANUS, DIPHTHERIA, AND PERTUSSIS (Tdap) VACCINATION CONSENT FORM

☐ Mother's ☐ Father's or ☐ Significant Other Name: _____Date of Birth _____/_____/_____

Mother's Maiden Name if it is the Mother receiving vaccine:_____

☐ Other: _____ (Example: Nursing staff, physician) Date of Birth _____/_____/_____

DO NOT GIVE THIS VACCINATION IF THE PERSON BEING VACCINATED HAS ANSWERED "YES" TO ANY OF THE FOLLOWING HEALTH QUESTIONS.

REFER TO: **PHONE NUMBER:**

VACCINE ADMINISTRATION RECORD

Type	Manufacturer & Lot #	Expiration Date	Injection Site	Injection Route	Administered By	VIS Date
Tdap	☐ SP Lot #_____ ☐ GSK Lot #_____		☐ RD ☐ LD	IM		10-4-07

RD=Right Deltoid **LD**=Left Deltoid **IM**=Intramuscular

1. Are you sick or do you have a high fever today?	☐ Yes	☐ No
2. Have you ever had Guillain-Barre´Syndrome?	☐ Yes	☐ No
3. Have you ever had a serious reaction after an immunization?	☐ Yes	☐ No
4. Have you been told you have an allergy to the antibiotics streptomycin or neomycin?	☐ Yes	☐ No
5. Do you have a seizure problem?	☐ Yes	☐ No

The following information is not required to receive the vaccine.

6. What is your race/ethnicity (one box only): ___ Native Hawaiian/Pacific Islander

___ White ___ Black/African American ___ Hispanic/Latino

___ Asian ___ American Indian/Alaska Native ___ Unknown/Refused

The following information is not required to receive the vaccine.

7. Highest level of education: ___ Technical school

___Less than high school ___ College ___ Advanced degree

___ High school graduate ___ College graduate ___ Unknown/refused

Signature **agreeing to receive vaccination**: _____ Date: _____/_____/_____

Signature indicating that I have been given the VIS information sheet on Tdap Vaccine and **I am declining the vaccination** at this time: _____ Date: _____/_____/_____

Reason for refusal: __ Fear of needles, __ Religious/personal beliefs, __Need for more information, ___Already had it

Form to be filed in the Consent section of medical record if this is for the patient

Form to be placed in special envelope into patient's medical record if this is for a support person to the patient.

If this is for a patient, i.e. Mother on Post Partum. Use her patient sticker. If for a non-patient, use the baby's sticker. For Hospital Staff/physician leave blank.

Patient Identification

CONSENTIMIENTO PARA LA VACUNA DE TETANUS, DIPHTHERIA, PERGUSSIS (TDAP)

Nombre actual de ☐ Madre ☐ Padre ☐ Otro significativo:_____ Fecha de nacimiento:____/____/____

Nombre de Soltera de la Madre:_____

(NO DE ESTA VACUNA SI LA PERSONA QUE SERA VACUNADA HA CONTESTADO "SÍ" A UNA DE LAS RESPUESTAS DE LAS SIGUIENTES PREGUNTAS.)

REFERIR AL: **NÚMERO DE TELÉFONO:**

VACCINE ADMINISTRATION RECORD

Type	Manufacturer & Lot #	Expiration Date	Injection Site	Injection Route	Administered By	VIS Date
Tdap	☐ SP Lot #_____ ☐ GSK Lot #_____		☐ RD ☐ LD	IM		10-4-07

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1. Esta enfermo hoy?	☐ Sí	☐ No
2. Ha tenido Síndrome Guillain-Barré?	☐ Sí	☐ No
3. Ha tenido una reacción severa después de recibir inmunizaciones?	☐ Sí	☐ No
4. Le han dicho que tiene una alergia a los antibioticos Streptomycin o Neomycin?	☐ Sí	☐ No
5. Tiene usted un problema de la incautación?	☐ Sí	☐ No
Si no Quieres responder a ninguno de estos preguntas, tienes derechoa decir que no lo quires firmar 6. Cuál es tu raza/perenencia étnica (una caja solamente): del ____ Hawainao del____ el desconocido nativo nativo del ____ americano del indio/de Alaska del ____ asiático del ____ el hispanico/de Latino del ____ americano Negro/africano del ____ blanco/pacífico del isleño/rechazó		
Si no Quieres responder a ninguno de estos preguntas, tienes derechoa decir que no lo quires firmar 7. Del más alto nivel de la educación: Los school___Less técnicos del ___ que desconocido del ___ del graduado de la universidad del ___ del graduado de la High School secundaria del ___ del grado avanzado del ___ de la universidad del ___ de la High School secundaria/rechazaron		

Firma indicando su acuerdo par recibir la vacuna_____ Fecha: _____/_____/_____

Firma indicando que me han dado la informacion para la vacuna Tdap y yo rehuso la vacuna en este tiempo:

_____ Fecha: _____/_____/_____

Reason for refusal ___ Fear of needles, ___ Religious/personal beliefs, ___Need for more information, ___Other

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