

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

<p>When was the last time your child received a Tetanus (Td/Dtap/Dt/Tdap) shot?</p> <p style="text-align: center;"> _____ / _____ / _____ UNKNOWN Month / Day / Year </p>

<p>Is this child sick today? yes no</p> <p>Does the child have allergies to medications/vaccines/foods? yes no</p> <p style="padding-left: 40px;">If yes, what? _____</p> <p>Has the child ever had a serious reaction to any vaccines?yes no</p>
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<p>Consent for Child's vaccination:</p> <p>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.</p> <p>I give consent to Hamilton County Public Health and its staff to vaccinate my child named on this form with the Tdap vaccine.</p> <p>Signature of Parent/Guardian: _____ Date: _____</p>
