



Tdap (Tetanus, Diphtheria, Pertussis) Immunization Consent Form

Recipient First and Last Name (Print): _____

Birth date: ____/____/____ Age: ____ Sex (M/F): _____

Please check YES or NO for each question, if you have any questions, please ask for assistance.

	YES	NO
1. Are you allergic to preservatives, neomycin, thimerosal, streptomycin or latex?	_____	_____
2. Do you have a history of Guillain-Barré Syndrome or active neurological disorder?	_____	_____
3. Have you ever had a serious reaction after receiving any vaccination?	_____	_____
4. Do you have a fever, diarrhea, or vomiting today?	_____	_____
5. For Women: Are you pregnant or suspect you are pregnant? If so, please speak with the nurse before receiving the Tdap vaccine.	_____	_____

CHECK WITH YOUR PHYSICIAN AND/OR YOUR HEALTHCARE PROVIDER BEFORE RECEIVING THIS VACCINE IF YOU CHECKED "YES" ON ANY OF THE ABOVE QUESTIONS.

PARTICIPANTS WHO SHOULD NOT TAKE THE VACCINE:

- Anyone who has had a life-threatening allergic reaction after a dose of DTP, DTaP, DT, or Td should not get Td or Tdap.
- Anyone who has a severe allergy to any component of al vaccine should not get that vaccine. Tell your provider if the person getting the vaccine has any severe allergies.
- Anyone who had a coma, or long or multiple seizures within 7 days after a dose of DTP or DTaP should not get Tdap, unless a cause other than the vaccine was found (these people can get Td).
- Talk with your provider if the person getting the vaccine: has epilepsy or another nervous system problem, had severe swelling or severe pain after a previous dose DTP, DTaP, DT, Td, or Tdap vaccine, or has had Guillain Barré Syndrome (GBS).
- Anyone who has a moderate or severe illness on the day the shot is scheduled should usually wait until they recover before getting Tdap or Td vaccine. A person with a mild illness or low fever can usually be vaccinated.

POSSIBLE SIDE EFFECTS FROM THE VACCINE:

- Most people have no side effects from Tdap vaccines. Injections are given by injection into a muscle of the upper arm. This may cause soreness for a day or two, mild fever, headache, tiredness, nausea, vomiting, diarrhea, stomach ache, chills, body aches, sore joints, rash, swollen glands.

THE VACCINE SHOT SHOULD NOT BE ADMINISTERED TO PEOPLE WITH ACUTE FEBRILE ILLNESS UNTIL THEIR TEMPORARY SYMPTOMS HAVE ABATED. HOWEVER, MINOR ILLNESSES WITH OR WITHOUT FEVER SHOULD NOT CONTRAINDICATE THE USE OF TDAP VACCINE, PARTICULARLY AMONG CHILDREN WITH MILD RESPIRATORY TRACT INFECTION OR ALLERGIC RHINITIS. **CONTRAINDICATIONS: THIS VACCINE SHOULD NOT BE ADMINISTERED TO ANYONE WITH A HISTORY OF HYPERSENSITIVITY TO ANY COMPONENT OF THE VACCINE INCLUDING THIMEROSAL.**

WARNING: PLEASE CHECK WITH YOUR PHYSICIAN BEFORE TAKING THE VACCINE.

CONSENT FOR SERVICES, MEDICAL RECORDS & HIPPA PRIVACY INFORMATION

I hereby acknowledge full and complete consent to and make request for an Tdap vaccination. I am physically able to have this vaccine and have never had an adverse reaction to an Tdap vaccine. I hereby request and authorize The Wellness Group, LLC's designated subcontractor who is an independent nurse/ healthcare staffing agency, not directly affiliated with The Wellness Group, LLC, to administer this vaccine to me or the person named above for whom I am the legal guardian. I hereby release The Wellness Group, LLC, its principals, directors, members, employees, affiliates, suppliers, providers, subcontractors, successors, agents, their respective insurance carriers, and the location sponsoring this clinic/program, its principals, directors, employees, affiliates, successors, or agents from any and all liability, injury or damage whatsoever arising from, or in any way connected with, this Tdap vaccine or the administration of same including, but not limited to, acts of negligence. I authorize my medical information herein to be shared with my physician/insurance. I have voluntarily requested this vaccine outside the course and scope of my employment. The Wellness Group, LLC will use and disclose your personal and health information to treat you, to receive payment for the care we provide, and for our other health care operations which generally include those activities we perform to improve quality care. We have prepared a detailed **NOTICE OF PRIVACY AND CONFIDENTIALITY PRACTICES** to help you better understand our policies in regards to your personal health information. I acknowledge that I have received a copy of the Notice of Privacy and Confidentiality Practices. I agree to remain in the general area for at least 15 minutes after receiving the vaccine. I acknowledge that I have received the appropriate Vaccine Information Statement (VIS) issued by the US Centers for Disease Control and Prevention for the vaccine being administered. **Please provide a copy of this form to your physician and/or healthcare provider for your medical records.**

Signature of Recipient or Legal Guardian Signature _____

Date of Service _____

Vaccine Information (Nurse Use Only)

MFR IM	Lot#	Exp. Date	Dosage Amount
Route	Left Deltoid	Right Deltoid	Admin. Date
Nurse Signature _____		Store or Company Name _____	