

County of Sacramento - Immunization Assistance Program

Tdap Screening and Consent Form

NOTE: If your child has been given a Tdap vaccine at age 7 or later, there is no need for another Tdap. Please take a proof of vaccine to your child's school

Please Read The Following Carefully Before Signing

For you/your child to be eligible to receive Tdap vaccine, **you must read, answer all questions, and sign this consent form.** Your answers to the questions listed below will help determine if you/your child will be able to receive the Tdap vaccine. Please read the Tdap Vaccine Information Statement provided.

NAME: _____ BIRTHDATE: _____ AGE: _____ SEX: Male or Female
(First) (Last) (mm-dd-yyyy)

PHONE: () _____ ADDRESS: _____ CITY: _____ ZIP: _____

NAME OF SCHOOL _____ TEACHER _____ GRADE _____

Please circle **Yes** or **No** for the following questions **and** answer **ALL** questions.

1) Does the person have any serious allergies to medications, food, latex or other substances?	Yes	No
2) Has the person ever had a bad reaction to a vaccine in the past? If yes, please explain: _____	Yes	No
3) Did the person ever have long or multiple seizures within 7 days after a dose of DTP or DTaP and no other cause was found?	Yes	No
4) Does the person suffer from seizures or epilepsy?	Yes	No
5) Does the person have any medical conditions for which s/he is seeing a doctor regularly? If yes, please write the medical condition(s): _____	Yes	No

I have been given a copy of the Vaccine Information Statement for the Tdap vaccine (Tdap/Td VIS, 11/18/08). I believe I understand the benefits and risks of the vaccine and request that the vaccine indicated above be given to me or to the person named above for whom I am authorized to sign.

Signature **Printed Name** **Date**

Parent's Information – Please print clearly.

Mother's First and Last Name: _____

Father's First and Last Name: _____

FOR CHILDREN 18 AND YOUNGER ONLY. Please complete the following information for our record keeping.

	Yes	No
Is the child American Indian or Alaskan Native?	<input type="checkbox"/>	<input type="checkbox"/>
Is the child covered by CHDP or Medi-Cal?	<input type="checkbox"/>	<input type="checkbox"/>
Does the child have private health insurance?	<input type="checkbox"/>	<input type="checkbox"/>
Is the child covered by Healthy Families?	<input type="checkbox"/>	<input type="checkbox"/>

Date:	Vaccine / Mfg:	Lot #	Exp. Date:	Screening MD/RN/LVN	IZ Given By:	Route/ Site
	Tdap 0.5 mL					IM LD RD