Central Coast VNA & Hospice
Tetanus/Diphtheria/Pertussis Booster Vaccination Consent & Contraindication Questionnaire Information
About Person Receiving Vaccine

1. PLEASE PRINT

2. Fill out all areas NOT shaded
3. Sign at "X" below

CLINIC CODE: ______ DATE: _________

VACCINATION: **Tetanus, Diphtheria, Pertussis (Tdap)____**

Cash ☐ Check #____________

Amount Paid: ___________

DO NOT WRITE IN ABOVE SECTION

Last Name	First Name	MI	Birth Date / / mo/day/year	Age	Male ☐ Female ☐

Address	City	State	Zip	Phone Number ( ) -

Please check appropriate box:		YES	NO
1	Are you allergic to thimerosal, latex rubber or formaldehyde?		
2	Are you sick with a fever?		
3	Do you have a bleeding disorder (hemophilia or thrombocytopenia, or on anticoagulant therapy)?		
4	Have you ever had a serious reaction to a previous dose of Tetanus/Diphtheria Toxoid Vaccine?		
5	Have you completed the primary immunizing course of Tetanus/Diphtheria Toxoid at least 10 years ago?		
6	Are you pregnant or nursing?		

I have read or have had explained to me the information about the Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis vaccine. Tdap vaccine contains 5 Lf of Tetanus toxoid, 2 Lf of diphtheria toxoid, and 2.5 mg detoxified pertussis toxin by assay. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that the vaccine be given to me or to the person named for whom I am authorized to make this request.

I understand that the vaccination is being provided by Visiting Nurse Association. I expressly release from any liability the above named organization and individual giving the vaccine. I, for myself, my heirs, executors, and assigns hereby agree to release the site provider and its employees from any and all claims arising out of, in connection with, or in any way related to my receipt of this vaccine in their facilities.

I agree to remain in the area at least 15 minutes and report back to the nurse if I experience any unusual side effects before leaving the premises. If any adverse effects from the Tdap vaccination occur after I leave, I agree to contact my physician.

Please make checks payable to VNA.

*X*_________________________________ __________
Signature of person receiving vaccine or person authorized to give permission if client is under 18 — Date

*X*_________________________________
I have received VNA Privacy Practices, VIS 11/18/08

☐ All "Yes" responses have been addressed. Given **Tetanus and Diphtheria Toxoid and Acellular PertussisVaccine** 0.5cc in _______ deltoid IM

Lot #______________________

____
Nurse's signature