HEALTH SCREEN & PERMISSION FORM – Tdap Vaccine

Please answer the following questions about the person to be vaccinated.

Full Name:	Date of Birth: / /	Age:	Gender: ☐ M ☐ F	School:
Street Address:	Town/City:		Zip Code:	Phone:
Grade:	Teacher:		SAU:	

Note: Anyone who has a moderate or severe illness on the day the shot is scheduled should usually wait until they recover before getting this vaccine. A person with a mild illness or low fever should be vaccinated.	**YES**	**NO**
1. Has this person had a life-threatening allergic reaction following any after a dose of tetanus, diphtheria, or pertussis containing vaccines or severe allergy to any component of the Td or Tdap vaccine?		
2. Has this person had a coma, or long or multiple seizures within 7 days after a dose of DTP or DTaP?		
3. Does this person have Epilepsy or another nervous system problem?		
4. Has this person had Guillain Barre Syndrome (GBS)?		
5. Has this person had severe swelling or severe pain after a previous dose of DTP, DTaP, DT, Td, or Tdap vaccine?		
6. **Health Care Provider Name (Doctor):**		
7. **Health Care Provider (Doctors office) Phone Number:**		
8. Is this person insured by MaineCare (Medicaid)? If yes, MaineCare ID #:		
9. Is this person an American Indian or an Alaskan Native?		
10. Is this person uninsured?		
11. Is this person under-insured (has insurance that does not cover Tdap vaccine)?		
12. Name of Health Insurance Carrier _____ ID Number: _____		

PERMISSION TO VACCINATE:

- ✍ I was given a copy of the Td or Tdap Vaccine Information Statement, I have read it or had it explained to me and I understand the benefits and risks of the Tdap vaccine.
- ✍ I give permission for a record of this vaccination to be entered into the ImmPact Registry
- ✍ I am giving my consent for this person to receive the most appropriate Tdap vaccine, as determined by the health care provider giving the vaccination.
- ✍ **I give permission for the vaccine to be given to the person named above by signing below.**

X _____

Signature of person to be vaccinated or signature of parent or guardian if person to be vaccinated is a minor

Parent or Guardian Name (please print):_____ Date:_____

FOR OFFICE USE ONLY:

Date Dose Administered	Vaccine	Vaccine Manufacturer	Lot Number	Dose Volume	Signature and Title of Vaccinator	Body Site	Route	VIS date
/ /							□ IM	1/24/12

Reviewed 10/26/12