**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? |  |  |
| 1. Has this person had a coma, or long or multiple seizures within 7 days after a dose of DTP or DTaP? |  |  |
| 1. Does this person have Epilepsy or another nervous system problem? |  |  |
| 1. Has this person had Guillain Barre Syndrome (GBS)? |  |  |
| 1. Has this person had severe swelling or severe pain after a previous dose of DTP, DTaP, DT, Td, or Tdap vaccine? |  |  |
| 1. **Health Care Provider Name:** 2. **Health Care Provider Phone Number:** | | |
| |  |  |  | | --- | --- | --- | | 1. Is this person insured by MaineCare (Medicaid)? If yes, MaineCare ID #: |  |  | | 1. Is this person an American Indian or an Alaskan Native? |  |  | | 1. Is this person uninsured? |  |  | | 1. Is this person under-insured (has insurance that does not cover Tdap vaccine)? |  |  | | 1. 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 |