

Td/Tdap Vaccine Consent Form

Must be 7 years of age or older (patients 7-12 must have a prescription)
 Must remain in pharmacy for 10 minutes after injection



PERSONAL INFORMATION

[PLACE RX LABEL HERE]	PATIENT PHONE: () -	
	DATE OF BIRTH: / /	AGE:
	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	
	COUNTY:	
	FAMILY DOCTOR:	
	MEDICARE/COMMERCIAL INSURANCE ID:	

SCREENING QUESTIONS

1. Are you currently sick with a fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you have a severe (life-threatening) allergy to latex or any component (or part) of this vaccine, including bovine casein, sodium chloride, aluminum phosphate, formaldehyde, ammonium sulfate, glutaraldehyde, 2-phenoxyethanol, aluminum hydroxide, and polysorbate 80?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever had a severe (life-threatening) allergic reaction to a previous dose of any vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever developed Guillain-Barre Syndrome within 6 weeks of receiving a vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had a seizure or a brain or other nervous system problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please remain in the pharmacy for 10 minutes following the vaccination. If you leave, you are doing so against medical advice.

I have read or have had explained to me the information in the Vaccine Information Statement about tetanus, diphtheria, and/or pertussis (Td/Tdap) vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of tetanus, diphtheria, and/or pertussis (Td/Tdap) vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request. I waive and release all claims I, or anyone claiming by or through me, now have or may hereafter acquire against Dr. James Schwieterman, MD, Schwieterman Pharmacies, and their respective directors, officers, employees, and agents for any damage or injuries if I, or the person named below for whom I am authorized to make this request, contact tetanus, diphtheria, pertussis, other diseases, or suffer any other adverse reactions following administration of this Td/Tdap vaccine. **I understand that I may be held responsible for charges that are not covered by my insurance. I understand that if I do not provide the proper insurance information I may also be held responsible for charges.** For Medicare Recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party that accepts assignment.



SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE THE REQUEST (PARENT OR LEGAL GUARDIAN)					DATE
-----FOR CLINIC/OFFICE USE ONLY-----					
IMMUNIZER:	TITLE:	DATE OF IMMUNIZATION:	VIS DATE (Td): 4/11/2017	VIS DATE (Tdap): 2/24/2015	SITE OF INJECTION: <input type="checkbox"/> LA/IM <input type="checkbox"/> RA/IM
VACCINE/MFG/DOSAGE: <input type="checkbox"/> Adacel/Sanofi/0.5ml Tdap (10-64 YO) <input type="checkbox"/> Boostrix/GSK/0.5ml Tdap (10 or older) <input type="checkbox"/> Tenivac/Sanofi/0.5ml Td (7 or older)			LOT #:	EXP DATE:	
INSURANCE: <input type="checkbox"/> Medicare <input type="checkbox"/> Rx Coverage <input type="checkbox"/> Major Med <input type="checkbox"/> Cash <input type="checkbox"/> _____			STORE: <input type="checkbox"/> CL <input type="checkbox"/> CW <input type="checkbox"/> MIN <input type="checkbox"/> NB <input type="checkbox"/> SM <input type="checkbox"/> WP		