543 W. Main St. - New Britain, CT 06053 - (860) 225-6487
233 Main St. - New Britain, CT 06051 - (860) 356-3270

# Tdap Vaccine Consent Form and Administration Record

*Personal Information (PLEASE PRINT)*

Name: _____ Date of Birth: _____ Sex: M F

Address: _____ City: _____

State: _____ Zipcode: _____ Phone Number: _____

| *Screening Checklist* | No | Yes | Don't Know |
|---|---|---|---|
| **1.** Are you feeling significantly sick today? *(ex: fever, nausea, etc.)* | ☐ | ☐ | ☐ |
| **2.** Do you have any allergies to medications, latex, or a vaccine component? *allergen and reaction (ex: hives/anaphylaxis):* _____ | ☐ | ☐ | ☐ |
| **3.** Have you had a Tdap vaccine within the past 10 years? | ☐ | ☐ | ☐ |
| **4.** Have you ever had a serious reaction after receiving a vaccine? | ☐ | ☐ | ☐ |
| **5.** Have you had/currently have a neurological disorder, seizures, or GBS? | ☐ | ☐ | ☐ |
| **6.** Are you pregnant or breastfeeding? | ☐ | ☐ | ☐ |

I have read or have had explained to me the Vaccine Information Statement about Tetanus/Diphtheria/Pertussis and the Tdap vaccine. I have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the Tdap vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent/guardian). *[VIS Edition Date 8/6/21]*

Patient/Guardian Signature _____ Date _____

[if guardian, relationship to patient] _____

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Vaccine Manufacturer: Sanofi Adacel (Tdap)

Lot #: _____ Expiration: _____

Dose: 0.5 mL Route: IM

Date Administered: _____ Location: Left Deltoid / Right Deltoid

Immunizer: _____ Title: Intern / Pharmacist

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# Insurance Information

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Insurance Company: _____
[used for insurance billing purposes only]

Cardholder Name: _____ Relationship: _____

Cardholder ID: _____ Rx BIN #: _____

PCN: _____ Rx Group #: _____

**Patient's copay to be collected prior to administration: $ _____*

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**PATIENT COPY**

# Tdap Vaccination Administration Record

Name: _____ Date of Birth: _____

Patient/Guardian Signature: _____ Date: _____

Vaccine Manufacturer: Sanofi Adacel (Tdap)

Lot #: _____ Expiration: _____

Dose: 0.5 mL Route: IM

Date Administered: _____ Location: Left Deltoid / Right Deltoid

Immunizer: _____