

EMPLOYEE WELLNESS, P.A.

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TD OR TDAP VACCINE CONSENT

PATIENT AUTHORIZATION AND NOTICE

TD

TDAP

Patient Name

Date of Birth

ADULT IMMUNIZATIONS – Screening Questionnaire (PLEASE READ)

The following questions will help us determine which vaccines you may be given today. If you answer “YES” to any question, it does not necessarily mean you should not be vaccinated, it just means additional questions must be asked. **If a question is not clear, please ask your healthcare provider to explain it.**

TD OR TDAP QUESTIONS:

- Are you sick today? YES NO
- Do you have allergies to medications, foods, or vaccines? YES NO
Including gelatin or the antibiotic neomycin or any other component of the shingles vaccine.
- Have you ever had a serious reaction after receiving a vaccination? YES NO
- Do you have a long-term health problem with heart disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorders? YES NO
- Do you have cancer, leukemia, AIDS, or any other immune system problems? YES NO
- Do you take cortisone, prednisone, other steroids, or anticancer drugs or have you had radiation treatments? YES NO
- Have you had a seizure or other nervous system problem? YES NO
- During the past year have you received a transfusion of blood or blood products? YES NO
- For women: Are you pregnant or is there a chance you could become pregnant? YES NO
- Have you received any vaccinations in the past 4 weeks? YES NO

I certify that I have been given the Td or Tdap CDC Vaccine Information Statement before my injection. I have reviewed the information sheet; understand the possible side effects and I feel I have no contraindications to the administration of the vaccine.

Signature of Recipient

Date

Witness

Vaccine Manufacturer

Lot Number

Exp. Date

Signature of Nurse

Injection Site:

Right Arm

Left Arm