Tdap Vaccination

(Tetanus, Diphtheria, & Acellular Pertussis)

(Please Print Information Here)

Name (first, last): _____

Department Name: _____ ☐ Volunteer ☐ Employee ☐ Student

Employee ID #: _____ Date of Birth: _____

Administration of Vaccine

Contraindications:

☐ **Yes** ☐ **No** Severe or life-threatening allergic reactions to tetanus toxoid, diphtheria toxoid or pertussis?

☐ **Yes** ☐ **No** Had a coma, decreased level of consciousness, or prolonged seizures within 7 days after a previous dose of any pertussis vaccine?

☐ **Yes** ☐ **No** Unstable neurologic disorder or history of seizures?

☐ **Yes** ☐ **No** History of Guillain-Barre Syndrome within 6 weeks of previous vaccination?

☐ **Yes** ☐ **No** Had severe pain or swelling after a previous dose of any vaccine that protects against tetanus or diptheria?

☐ **Yes** ☐ **No** Are you currently, moderately or severely ill?

☐ Yes, I have received the VIS form dated (**08/06/2021**) and have reviewed the information about the risks and benefits of the Tdap vaccine and consent to receiving the Tdap vaccine.

Date (Reviewed VIS): _____ **Patient Signature:** _____

If the above patient/employee is under the age of 18, they must be accompanied by a parent/guardian.

Parent/Guardian Signature: _____

Date of Admin: _____ **Time:** _____ **Site:** ☐ Left Upper Arm ☐ Right Upper Arm **Dose (sticker):**

Manufacturer: _____ **Lot #:** _____ **Exp. Date:** _____

Administered/Reviewed By (include full name and title): _____

Waiver of Vaccine Only

IMPORTANT INFORMATION

Persons who have not been immunized will be required to wear an isolation mask at all times except when they are in designated eating areas such as breakrooms, cafeterias, coffee shops, or tea rooms as required by the Communicable Disease Work Restrictions policy.

Date: _____ **Patient Signature:** _____

Date: _____ **Witness Signature:** _____

BLESSING HEALTH