2020-2021 TDaP Vaccine Consent Form

THIS FORM MUST BE RETURNED

PLEASE COMPLETE THE INFORMATION BELOW
(Unreadable and incomplete forms may not be accepted.)

Full Legal Name of Student (First Name Middle Initial. Last Name) PLEASE PRINT				Student No.:	Name of School
Parent/Guardian Name (First Name Middle Initial. Last Name) / Relationship to Student				Grade	Homeroom Teacher
Birth Date (month/date/year)	Age	Sex	Ethnicity - (Check 1) ___ Hispanic or Latino ___ Not Hispanic or Latino	Race - (Check 1 or more) ____ American Indian or Alaska Native ____ Asian ____ Black or African American ____ Native Hawaiian / Pacific Islander ____ White ____ Other	
Street Address			Email Address		
City			Zip Code		
Home Phone#	Cell Phone#				

Insurance (Check 1) ___ No Insurance ___ Medicaid ___ Privately Insured

You will not be billed, and there is no co-pay or deductible due. The service is offered at no cost to you! As always, answers are confidential.

HEALTH QUESTIONS: CHECK YES OR NO FOR EACH QUESTION

YES	NO	
_____	_____	1. Has your child had a fever within the last 24 hours?
_____	_____	2. Has your child ever had a serious reaction to any vaccine in the past or after a previous dose of diphtheria, tetanus, pertussis containing vaccine?
_____	_____	3. Has your child ever had Guillain-Barre syndrome or a history of siezures?
_____	_____	4. Does your child have any allergies to food, medication, or latex?

If **YES** to any of the above, please specify: _____.

I have received, read and understand the CDC Vaccine Information Statement for the TDaP vaccine and the Notice of Privacy Practices. I have read these documents and understand the risk and benefits of the Tdap vaccine. I give permission to the State of Florida, Department of Health to give my child the vaccine in my absence, to communicate with other healthcare providers, as needed, and for data entry, billing and storage according to Florida Department of Health policies, to assure optimal healthcare for my child.

☐ **Yes, I want my child to receive the TDaP vaccine.**

_____ Printed Name of Parent/Guardian

_____ Signature of Parent/Guardian

_____ Date

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

Date Given	Route/Site		Signature/Title
	RDT/IM	LDT/IM	

Nurse's Notes: