TDAP VACCINE CLINIC

WHEN
Monday, May 10th, 2021

WHERE
Nims Middle School

WHY
The COVID-19 pandemic has caused regular scheduled doctor's appointments to be missed.

The Leon County Health Department is offering Tdap immunizations for sixth graders transitioning to seventh grade. **The Tdap vaccine is a required immunization for seventh graders.** Health department nurses will be administering the vaccine during school hours to students with consent forms.

Please return the attached consent forms to your student's school clinic or to LeonSchoolHealth@flhealth.gov no later than Friday, May 7th, 2021.

Florida HEALTH
Leon County

Tdap vaccine can prevent tetanus, diphtheria, and pertussis. Diphtheria and pertussis spread from person to person. Tetanus enters the body through cuts or wounds.

TETANUS (T) causes painful stiffening of the muscles. Tetanus can lead to serious health problems, including being unable to open the mouth, having trouble swallowing and breathing, or death.

DIPHTHERIA (D) can lead to difficulty breathing, heart failure, paralysis, or death.

PERTUSSIS (aP), also known as "whooping cough," can cause uncontrollable, violent coughing which makes it hard to breathe, eat, or drink. Pertussis can be extremely serious in babies and young children, causing pneumonia, convulsions, brain damage, or death. In teens and adults, it can cause weight loss, loss of bladder control, passing out, and rib fractures from severe coughing.

INITIATION OF SERVICES

PART I **CLIENT-PROVIDER RELATIONSHIP CONSENT**

Client Name: _____

Name of Agency: Leon County Health Department - School Health Division

Agency Address: 2965 Municipal Way; Tallahassee, FL 32304

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical visits including obtaining medical history, assessment, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

PART II **DISCLOSURE OF INFORMATION CONSENT** (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my health information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

PART III **MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST** (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my health information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above-named agency and authorize it to submit a claim to Medicare for payment.

PART IV **ASSIGNMENT OF BENEFITS** (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above-named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V **COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER**

(This notice is provided pursuant to Section 119.071(5)(a), Florida Statutes.)

For health care programs, the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071(5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

PART VI **MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS**

_____ _____ _____

Client/Representative Signature | Self or Representative's Relationship to Client | Date

_____ _____

Witness (optional) | Date

PART VII **WITHDRAWAL OF CONSENT**

I, _____ WITHDRAW THIS CONSENT, effective _____

Client/Representative Signature | Date

_____ _____

Witness (optional) | Date

Client Name: _____

ID#: _____

DOB: _____

Original to file; Copy to client

DH 3204-SSG-09-2019

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:

VACCINE INFORMATION STATEMENT

Tdap (Tetanus, Diphtheria, Pertussis) Vaccine: *What You Need to Know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Tdap vaccine can prevent **tetanus, diphtheria**, and **pertussis**.

Diphtheria and pertussis spread from person to person. Tetanus enters the body through cuts or wounds.

- **TETANUS (T)** causes painful stiffening of the muscles. Tetanus can lead to serious health problems, including being unable to open the mouth, having trouble swallowing and breathing, or death.
- **DIPHTHERIA (D)** can lead to difficulty breathing, heart failure, paralysis, or death.
- **PERTUSSIS (aP)**, also known as "whooping cough," can cause uncontrollable, violent coughing which makes it hard to breathe, eat, or drink. Pertussis can be extremely serious in babies and young children, causing pneumonia, convulsions, brain damage, or death. In teens and adults, it can cause weight loss, loss of bladder control, passing out, and rib fractures from severe coughing.

2 Tdap vaccine

Tdap is only for children 7 years and older, adolescents, and adults.

Adolescents should receive a single dose of Tdap, preferably at age 11 or 12 years.

Pregnant women should get a dose of Tdap during every pregnancy, to protect the newborn from pertussis. Infants are most at risk for severe, life-threatening complications from pertussis.

Adults who have never received Tdap should get a dose of Tdap.

Also, **adults should receive a booster dose every 10 years**, or earlier in the case of a severe and dirty wound or burn. Booster doses can be either Tdap or Td (a different vaccine that protects against tetanus and diphtheria but not pertussis).

Tdap may be given at the same time as other vaccines.

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of any vaccine that protects against tetanus, diphtheria, or pertussis**, or has any **severe, life-threatening allergies**.
- Has had a **coma, decreased level of consciousness, or prolonged seizures within 7 days after a previous dose of any pertussis vaccine (DTP, DTaP, or Tdap)**.
- Has **seizures or another nervous system problem**.
- Has ever had **Guillain-Barré Syndrome** (also called GBS).
- Has had **severe pain or swelling after a previous dose of any vaccine that protects against tetanus or diphtheria**.

In some cases, your health care provider may decide to postpone Tdap vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting Tdap vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

- Pain, redness, or swelling where the shot was given, mild fever, headache, feeling tired, and nausea, vomiting, diarrhea, or stomachache sometimes happen after Tdap vaccine.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do not give medical advice.*

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at **www.cdc.gov/vaccines**