

## Portage County Local Health Departments 2010 Tdap Vaccine Consent Form

### Section 1: Information about Child to Receive Vaccine (please print)

STUDENT'S NAME (Last)		(First)	(M.I.)	STUDENT'S DATE OF BIRTH		
				Month	Day	Year
PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)	STUDENT'S AGE		STUDENT'S GENDER
						M / F
ADDRESS				PARENT/GUARDIAN DAYTIME PHONE NUMBER:		
CITY	STATE	ZIP	TWP			
SCHOOL NAME				GRADE		

### Section 2: Screening for Vaccine Eligibility

When was the last time your child received Tetanus containing vaccine \_\_\_\_\_ (if less than 2 years you can not receive a Tdap). (DATE)

**Please mark YES or NO for each question.**

If you answer "NO" to all five of the following questions, your child can get a Tdap/Td vaccine.

If you answer "YES" to one or more of the following five questions, your child won't be able to receive Tdap/Td vaccine

	YES	NO
1. Is your child sick today?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have any other serious allergies that you know of? Please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child ever had a serious reaction to a previous vaccine before?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has your child ever had a seizure following a vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your child have Guillain Barre Syndrome (GBS)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has your child had a reaction to Dtap or a Td vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

### Section 3: Consent

<b>CONSENT FOR CHILD'S VACCINATION:</b>	
I have read or had explained to me the Vaccine Information Statement for Tdap/Td vaccine and understand the risks and benefits.	
I GIVE CONSENT to the STATE/LOCAL health department and its staff for my child named at the top of this form to get vaccinated with this vaccine. (If this consent form is not signed, dated, and returned, then your child will not be vaccinated at school.)	
Signature of Parent/Legal Guardian _____	
Date: month _____ day _____ year _____	

### Section 4: Payment *No one shall be denied services due to inability to pay.*

Fee for service: \$10.00

Payable by cash, check, or Medicaid plan

- I am paying with cash.
- I would like a receipt.
- I cannot pay.

Check # \_\_\_\_\_ Please write checks to "PORTAGE COUNTY HEALTH DEPARTMENT"

Medicaid Plan (Please write Medicaid plan number and attach a copy of your plan)

BUCKEYE
CARE SOURCE
MEDICAID
UNISON

# \_\_\_\_\_ # \_\_\_\_\_ # \_\_\_\_\_ # \_\_\_\_\_

### Section 5: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Dose Number	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
	/ /	IM				