MARION COUNTY PUBLIC HEALTH DEPARTMENT
TDAP VACCINE PARENT CONSENT FORM

Information about person to receive vaccine (PLEASE PRINT)			
Name: Last First MI			Birth Date Age
Address:			Male ☐ Female ☐
City:	State:	Zip:	County:
Phone Number:			

FOR TRACKING PURPOSES PLEASE MARK ONE: ☐ INSURED ☐ NOT INSURED ☐ MEDICAID

1. Is the child currently taking antibiotics for any purpose? ☐ Yes ☐ No
   If yes, which antibiotic(s)? _____
2. Does the child have any food or medication allergies? ☐ Yes ☐ No
   If yes, which food or medication? _____
3. Has the child had a serious reaction to a vaccine in the past? ☐ Yes ☐ No
   If yes, which vaccine(s) and what occurred? _____
4. Has the child received vaccinations in the past 4 weeks? ☐ Yes ☐ No
5. Does the child have any neurological disease (brain) or history of seizure? ☐ Yes ☐ No
6. Does the child have cancer or is the child on medications that lower the body's resistance to infection? ☐ Yes ☐ No
7. Is the child/teen pregnant or is there a chance she could be pregnant? ☐ Yes ☐ No

SECTION III: ***Acknowledgement of receipt of the Notice of Privacy Practice***

I understand, that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). The Notice of Privacy Practice has been made available to me which explains those rights.

PARENT/GUARDIAN SIGNATURE _____ DATE_____

I understand the risks and benefits of the vaccine being given and ask that the vaccine be given to the student for whom I am authorized to make this request. I have had a chance to ask questions which were answered to my satisfaction.

PARENT/GUARDIAN SIGNATURE _____ DATE_____

For Clinic Use						
Vaccine	**Date**	**Manufacturer**	**Site**	**Lot # (includes dashes)**	**Dosage**	**Administered by:**
Tdap					0.5	