Tdap VACCINE CONSENT FORM

Information about person to be vaccinated ***(Please print)***

Last Name:_____

First Name: _____ Age: _____

Date of Birth: _____ Sex: _____ M _____ F

Address: _____ _____ _____ _____

City: _____ Zip: _____

Parent/Guardian: _____

Phone number: _____

(For office use only)

Clinic/POD:

★ State Law requires1 dose for Middle School entry

★ Children who have received a prior dose of Tdap at age 7 or after do not need to be re-vaccinated

The South Dakota Immunization Information System (SDIIS) is an automated system to document vaccinations given in South Dakota. SDIIS will give parents access to their child's immunization record from any participating South Dakota provider. SDIIS also allows providers to send reminder notices regarding needed immunizations. Health care providers, health care facilities, federal or state agencies, welfare agencies, school or family day care facilities may have access to this information. Immunization records remain confidential, and any person who fails to protect the confidentiality of this information is guilty of a Class 1 misdemeanor. If you choose **NOT** to have your/your child's immunization record shared with other providers you may request a refusal form.

For a child being vaccinated - check any that apply

_____ Enrolled in Medicaid
_____ No health insurance
_____ Health Insurance
_____ American Indian or Alaskan Native
_____ Health insurance DOES NOT pay for vaccines

Please answer the following questions for the person to be vaccinated:

	YES	NO	Don't Know
1) Is the child sick today?	_____	_____	_____
2) Does the child have allergies to medications, food, a vaccine component, or latex?	_____	_____	_____
3) Has the child ever had a serious reaction to a vaccine in the past?	_____	_____	_____
4) Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	_____	_____	_____

CONSENT for Vaccination

I have been provided a copy of and have had explained to me the information about the Tetanus, Diphtheria, Pertussis diseases and the Tdap vaccine. I have had the chance to ask questions that were answered to my satisfaction.
I believe I understand the benefits and the risks of the vaccine and ask that the vaccine be given to the child above for whom I am authorized to make this request.

Signature _____ **Date** _____

(Parent or guardian)

for office use only

	Date/Time	Vaccine Manufacturer	Vaccine Lot number	Route	Site **(Circle)**	Date of VIS Publication	Full signature of person administering vaccine
Tdap Vaccine				IM *	Left Deltoid Right Deltoid	2/24/15	

The Department of Health Notice of Privacy Practices can be found on the following website: http://doh.sd.gov/documents/HIPAANotice.pdf

* IM-intramuscularly

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