Td/Tdap Vaccine Consent Form

Must remain in pharmacy for 10 minutes after injection

Aston Pharmacy Home Health Center
"Where caring is the heart of our business"

PERSONAL INFORMATION

1/31/25 Vaccine Information Statement

Please scan and read.

Paper version available by request.

PATIENT PHONE:
( ) -

DATE OF BIRTH:
/ /

AGE:

☐ FEMALE ☐ MALE

Address:

Family Doctor:

SCREENING QUESTIONS

Are you currently sick with a fever?	☐ Yes ☐ No
Do you have a severe (life-threatening) allergy to latex or any component (or part) of this vaccine, including aluminum phosphate, formaldehyde, glutaraldehyde, 2-phenoxyethanol, sodium chloride, and polysorbate?	☐ Yes ☐ No
Have you ever had a severe (life-threatening) allergic reaction to a previous dose of any vaccine?	☐ Yes ☐ No
Have you ever developed Guillain-Barre Syndrome within 6 weeks of receiving a vaccine?	☐ Yes ☐ No
Have you had a seizure or a brain or other nervous system problem?	☐ Yes ☐ No

Please remain in the pharmacy for 10 minutes following the vaccination. If you leave, you are doing so against medical advice.

I have read or have had explained to me the information in the Vaccine Information Statement about tetanus, diphtheria, and/or pertussis (Td/Tdap) vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of tetanus, diphtheria, and/or pertussis (Td/Tdap) vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request. I waive and release all claims I, or anyone claiming by or through me, now have or may hereafter acquire against Aston Pharmacy Home Health Center, and their respective directors, officers, employees, and agents for any damage or injuries if I, or the person named below for whom I am authorized to make this request, contract tetanus, diphtheria, pertussis, other diseases, or suffer any other adverse reactions following administration of this Td/Tdap vaccine. **I understand that I may be held responsible for charges that are not covered by my insurance. I understand that if I do not provide the proper insurance information I may also be held responsible for charges.** For Medicare Recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party that accepts assignment.

SIGN

SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE THE REQUEST (PARENT OR LEGAL GUARDIAN) **DATE**

----------FOR CLINIC/OFFICE USE ONLY----------

IMMUNIZER:	TITLE:	DATE OF IMMUNIZATION:	VIS DATE: 01/31/2025	SITE OF INJECTION: ☐ LA/IM ☐ RA/IM

VACCINE/MFG/DOSAGE:	LOT #:	EXP DATE:
☐ Adacel/Sanofi/0.5ml ☐ Boostrix/GSK/0.5ml ☐ Tenivac/Sanofi/0.5ml Tdap (10-64 YO) Tdap (10 or older) Td (7 or older)		

Updated 9/2/25

For office use only: ____ Billed ____ Scanned ____ PIERS ____ Faxed PCP