Tetanus & Diphtheria (Tdap) Consent Form & Vaccine Administration Record

Tetanus, diphtheria and Pertussis -- TETANUS is an acute, sometimes fatal, disease of the central nervous system, caused by the toxin of the tetanus bacterium, which usually enters the body through an open wound. It causes painful muscle tightening and stiffness, usually all over the body. The tetanus bacterium lives in soil and manure, but also can be found in the human intestine and other places. Tetanus enters the body through cuts, scratches, or wounds. DIPHTHERIA can cause a thick coating to form in the back of the throat. It can lead to breathing problems, heart failure, paralysis, and death. PERTUSSIS (Whooping Cough) causes severe coughing spells, which can cause difficulty breathing, vomiting, and disturbed sleep. These diseases are caused by bacteria. Diphtheria and pertussis are spread from person to person through secretions from coughing or sneezing.

The Vaccine --Tdap vaccine can protect adolescents and adults from tetanus, diphtheria, and pertussis. The vaccine is made from a dead virus. We recommend that you remain on site for up to 15 minutes following the injection to monitor for possible vaccine reactions. A booster vaccine should be administered every 10 years once the original series is completed.

Risks and Possible Side Effects -- Side effects of Tdap vaccine are generally mild in adults. These reactions consist of pain and redness where the shot was given, slight fever and fatigue. These symptoms may last up to 48 hours. An immediate possible allergic reaction rarely occurs after a tetanus vaccination. This probably results from an allergy to a component in the vaccine.

Special Precautions -- Pregnant women and persons with a serious illness should consult their physician before receiving the tetanus vaccine. Persons who are allergic to latex should notify the provider prior to receiving this vaccination.

DO NOT receive this vaccine if you have an active infection or fever.
DO NOT receive this vaccine if you have had a serious reaction to the tetanus or diphtheria toxoid (Td) vaccine in the past.

INFORMATION CONCERNING PERSON TO RECEIVE TETANUS VACCINE:

NAME (please print) DATE OF BIRTH AGE PHONE NUMBER

ADDRESS CITY STATE ZIP

DO YOU HAVE ALLERGIES TO: □ Latex □ Tetanus vaccine or a Tetanus toxoid component □ Other_____

ARE YOU PREGNANT? □ Yes □ No

ARE YOU CURRENTLY GETTING TREATMENT FOR HODGKIN'S DISEASE? □ Yes □ No

HAVE YOU RECEIVED A TETNUS VACCINE IN THE LAST 10 YEARS? □ Yes □ No □ Don't know

NAME & ADDRESS OF FAMILY PHYSICIAN

CONSENT:
I have read the above information and have had an opportunity to ask questions. I understand the benefits and risks of the tetanus vaccine as described. I request that the vaccine be given to me or to the person named below for whom I am authorized to sign.

SIGNATURE OF PERSON RECEIVING or AUTHORIZING VACCINE DATE

~~Td Vaccination Information (*office use only*)~~

Aventis / Lot #:_____ Exp. / /

Dose: 0.5mL Admin. Site: R L Arm Thigh

Amount Paid:_____

Signature & Title of
Vaccine Administrator:_____

Date Administered:_____


Madison Ave.
Pharmacy