**Consent for Tetanus, Diphtheria, and Pertussis (TDap) Vaccine**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent**

* I have received the TDap Vaccine Information Statement.

* I understand the risks and benefits of receiving this vaccine as stated in the

VIS. I further understand that if I have a reaction to this vaccine the Birth Center staff will direct me to the Emergency Department to receive appropriate treatment.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vaccination Information Record: (One booster with in last 10 years. A single dose of TDap recommended for all students.)**

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| --- | --- | --- | --- | --- | --- |
| **TYPE** | **Manufacturer and Lot #** | **Expiration Date** | **Injection Site and Route** | **Administered By** | **VIS Date** |
| TDap | SP Lot #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    GSK Lot #\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Left Deltoid--IM    Right Deltoid--IM    Other--IM:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

**Physician’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**