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

**Name:** ________________________________________ **Date:** _________________

**Consent**

☐ I have received the TDap Vaccine Information Statement.

**Declination**

☐ I understand that due to my exposure to patients at healthcare facilities, I may be at risk of acquiring an infection with pertussis and by declining the Tdap vaccine; I continue to be at risk of acquiring a serious disease.

**Signature:** _____________________________________ **Date:** _________________

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

| TYPE | Manufacturer and Lot # | Expiration Date | Injection Site and Route | Administered By | VIS Date |
|---|---|---|---|---|---|
| TDap | ☐SP Lot #_______________<br>☐GSK Lot #______________ | | ☐Left Deltoid--IM<br>☐Right Deltoid--IM<br>☐Other--IM:<br>_________________ | | |

**Physician's Signature**__________________________________ **Date**___________________

MAIN CAMPUS
360 Choate Avenue
Buffalo, NY 14220
716-826-1200

2262 Seneca Street
Buffalo, NY 14210
716.826.1200

EXTENSION CENTER
6681 Transit Road
Williamsville, NY 14221
716-827-4300