Alameda Acute Care Clinic & Family Medicine

TD/TDAP VACCINATION CONSENT FORM

Patient Information:

First Name: _____Middle:_____Last name:_____

Please check ( ) next to each statement that applies:

[ ] I have received and read the Vaccine Information Statement on Td/Tdap, including contraindications and side effects.

[ ] Before receiving an injection, I will ask questions of the provider if I have any.

[ ] I will inform the provider of any allergies prior to receiving the immunization, and note them here:

[ ] I understand that, as with any vaccine or drug, there is a possibility, however remote, that serious allergic reactions or even death could occur.

[ ] I understand the benefits and risks of the vaccine and request that it be given to me.

[ ] I agree to remain in the Health Services Clinic for 15-20 minutes following injection to be observed for any sign of adverse reaction.

I have read or had explained to me the Vaccination Information Statement about TD/TDAP vaccination and I understand the benefits and risks of TD/TDAP vaccination. I request that the TD/TDAP vaccination be given to me (or the person named above for whom I am authorized to make this request).

Signature: _____ Date: _____

Name:_____Relationship to patient: _____

To be completed by person administering vaccine:

Today's date:_____Site of Injection (circle one): R L
Lot #:_____Expiration Date: _____
Medical Record #:_____Room #: _____
Administered by: _____