San Diego Unified SCHOOL DISTRICT

Nursing & Wellness Program

Tdap Booster Immunization Consent Form – _____ School

Important: PLEASE READ AND FILL IN THE BLANKS BELOW AND SIGN THIS FORM.

Student's Last Name: _____ **First Name:** _____

Birthdate: _____ **Age:** _____

Address: _____ **Phone:** _____

SCREENING QUESTIONNAIRE FOR STUDENT IMMUNIZATION

Please circle Yes or No for the following questions and answer all questions.

1. Does the child have allergies to medications, food, a vaccine component, or latex? **Yes** **No**
2. Does the child have an allergy to thimerosal and/or formaldehyde? **Yes** **No**
3. Has the child had an allergic reaction to the Tetanus/Diphtheria/Pertussis vaccine or any other vaccine in the past? **Yes** **No**
4. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems? **Yes** **No**
5. Has the child ever had a coma or long multiple seizures within 7 days after a dose of Tetanus/ Diphtheria/Pertussis containing vaccine? **Yes** **No**
6. Does your child have Medi-Cal? **Yes** **No**
7. Does your child have Healthy Families or other health insurance? **Yes** **No**

Note: Child will not be vaccinated on clinic day if he/she has fever, severe diarrhea or vomiting.

I have read the information contained in "Important Information" form about the disease and the vaccine below, or have had it explained to me. I have had a chance to ask questions, which were answered to my satisfaction. I understand the benefits and risks of the vaccine and request that the Tdap vaccine be given to the person named above for whom I am authorized to make this request. I understand that, depending on the answers to the questions listed above, my child may receive the Tdap vaccine at his/her school. I give permission for my child whose name is listed above to receive the Tetanus, Diphtheria and Acellular Pertussis vaccine. **I understand information on immunizations given to me or to the person named above, will be released to other medical care providers to avoid unnecessary vaccination or to check immunization status. If I do not want to share the immunization record, I will contact SDIR/CAIR at (619) 692-5656.**

X _____ _____

SIGNATURE: Parent/Guardian **Date**

Date	Site LD RD	Vaccine Lot #	Form reviewed by/Vaccinator _____RN	SDIR entry