CATAWBA COUNTY PUBLIC HEALTH
Tdap CONSENT FORM

Client Name (Please Print) _____ Date of Birth _____ Race _____ Sex _____

Social Security Number _____

Street Address/Mailing Address _____ Daytime Telephone Number _____

City _____ State _____ Zip _____ Night Telephone Number _____

The clinic may keep this record in your medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the signature and title of the person who gave the vaccine, and the location the vaccine was given.
I have read or have had explained to me the information on this form about diphtheria, tetanus and pertussis infections and the Tdap vaccine. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of Tdap vaccine and desire the vaccine be given to me. I confirm that I have had an opportunity to review Catawba County Public Health's Notice of Privacy Practices.

_____ Signature

_____ Date

Allergies: NO_____ YES_____ **If yes, allergic to:** _____

THIS SECTION TO BE COMPLETED BY NURSE

Vaccine	Brand	Date	Site	Lot #	VIS Date	Staff ID #/ Provider Signature
Tdap	Boostrix				1/24/12	
	CPT Codes	874	90715-ST	Tdap	V06.9	
	CPT Codes	3146	90471-ST	Vaccine administration	V06.9	

RStikeleather: June 2012