City of Hamilton Health Department
2010 Tdap (Tetanus, Diphtheria and Pertussis) Vaccine Consent Form

Section 1: Information about Child to Receive Vaccine (please print)

STUDENT'S NAME (Last)	(First)	(M.I.)	**STUDENT'S DATE OF BIRTH** **month_____ day_____ year_____**	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	**STUDENT'S AGE**	**STUDENT'S GENDER** ☐ **M** ☐ **F**
ADDRESS			**PARENT/GUARDIAN DAYTIME PHONE NUMBER:**	
CITY	**STATE**	**ZIP**		
SCHOOL NAME	**Student's Race**		**GRADE**	

Section 2: Screening for Vaccine Eligibility

When was the last time your child received a Tetanus containing vaccine? (DTaP, Tdap, TD, or Td)

Date Received: Month _____ Day _____ Year _____

Check the correct response

Is your child sick today?	☐ Yes	☐ No
Does this child have a life threatening allergy to food, medicine or vaccines?	☐ Yes	☐ No
Has this child had a serious reaction following a vaccine?	☐ Yes	☐ No
Has this child had a seizure, brain or other neurvous system problem?	☐ Yes	☐ No

Check one: ☐ **Caresource** ☐ **Amerigroup** ☐ **Molina** ☐ **Medicaid**

- ☐ **My child has Medicaid health insurance. Please provide the billing number_____**
- ☐ **Our health insurance does not cover vaccines.**
- ☐ **We have no health insurance.**
- ☐ **We have other health insurance which does pay for vaccines.**

Section 3: Consent

Consent for Child's Vaccination:

I have read or had explained to me the Tdap Vaccine Information Statement and understand the risks and benefits. I have read and received a copy of the City of Hamilton Health Department Privacy Policy. I grant permission for this record to be released to providers, schools, immunization registry databases and others as is necessary.

I GIVE CONSENT to the City of Hamilton Health Department and their staff for my child named at the top of this form to get vaccinated with this vaccine. (If this form is not signed, dated and returned to school, then your child will not be vaccinated at school.

Signature of Parent/ Legal Guardian _____

Date: Month _____Day _____ Year _____

Section 4: Vaccination Record

Date of Administration	Tdap Vaccine/ Manufacturer	Name and Title of Vaccine Administartor