

Tdap, (tetanus, diphtheria, and pertussis) McElroy Pharmacy Immunization Consent Form

Name: _____

DOB: _____

Primary Physician: _____

Please circle YES or NO for each question.

1. Are you allergic to preservatives, neomycin, thimerosal, streptomycin or latex? YES NO
2. Do you have a history of Guillain-Barré Syndrome or active neurological disorder? YES NO
3. Have you ever had a serious reaction after receiving any vaccination? YES NO
4. Do you have a fever, diarrhea, or vomiting today? YES NO
5. For Women: Are you pregnant or suspect you are pregnant? YES NO

POSSIBLE SIDE EFFECTS FROM THE VACCINE:

Most people have no side effects from Tdap vaccines. Injections are given into a muscle in the upper arm. This may cause soreness for a day or two, redness or swelling at the injection site, mild fever, headache, tiredness, nausea, vomiting, diarrhea, stomach ache, chills, body aches, sore joints and rash.

CONSENT FOR SERVICES: I have been given and have read a copy of the Vaccine Information Statement (VIS). I understand the risks and benefits of the Tdap vaccination and I am requesting that I be vaccinated with Tdap. _____ (initials)

Stop. Do not write below this line.

Vaccine administered: Tdap (tetanus, diphtheria, and pertussis)
Dose: 0.5 ml Route: IM Site: (Left / Right) deltoid
Lot #: _____ Exp: _____

Administered by: _____ **Date:** _____
McElroy Pharmacy P:717-626-2222 F:717-626-7920

---Please Update Vaccination Records Accordingly! Thank You---