

HIGHLANDS HEALTH SYSTEM

TETNUS, DIPHTHERIA, PERTUSSIS (Tdap) VACCINE CONSENT

I have read the vaccine information sheet (VIS) about Tdap and Tdap vaccine. I have had the opportunity to ask the hospital's Employee Health Nurse or designee any and all questions that I may have about the information on this form and the vaccine. I hereby acknowledge that I have been informed of the nature and advisability of the risks and complications inherent in and expected benefits of the alternatives to and their risks and benefits and the probable consequences of the receiving Tdap vaccination.

However, as with all medical treatment, I recognize that there is no guarantee that I will become immune or that I will not experience an adverse side effect from the vaccine. By my signature below, I hereby give consent for Tdap vaccination.

I hereby acknowledge that the following has been explained:

- I should not receive the vaccine, if I have a life-threatening allergic reaction after a dose of DTP, DTaP, DT, or Td vaccine;
- I should not receive the vaccine, if I have had a severe allergy to any component of the vaccine;
- I should not receive the vaccine, if I have a severe allergy to latex;
- I should not receive the vaccine, if I went into a coma or had a long seizure within 7 days after a dose of DTP or Dtap;
- I should not receive the vaccine if I have moderate or severe illness;
- I should discuss getting the vaccine with my physician before the vaccine if I have had any of the following: Epilepsy, Pertussis, Guillain Barre Syndrome or Severe swelling or pain after a previous dose of any vaccine containing tetanus, diphtheria, or pertussis

Name: Tushar Shah Department: Physician

Social Security # 079-48-2910 Date of Birth: 7/26/66

Signature (individual to receive vaccine): [Signature] Date: 6/15/15

Witness (licensed personnel): Vickie Risner Date: 6/15/15

Vaccine Information Statement (VIS), Tdap Vaccine (5/9/13) U.S.C. 42 § 300aa-26 provided.

Date Given: 6/15/15 Given By: Vickie Risner RN, MSW

Lot # AG 7KY Expiration Date: 5/28/16

Comments: Given (S) Deltoid tolerated well

DECLINE:

Notwithstanding the forgoing information, by my signature below, I hereby refuse vaccine.

Name of Person Declining Vaccine (Print): _____

Signature of Person Declining Vaccine: _____