Northeast Tennessee Public Health School Located TDAP Vaccination Project
Student Consent Form and TDAP Vaccine Immunization Nursing Record

If you want a TDAP Vaccination given to your child, COMPLETE THE INFORMATION ON THE FRONT AND BACK OF THIS FORM AND SIGN. Your signature will allow your child to receive the TDAP vaccine (shot) depending upon your answers to the following important questions:

PLEASE PRINT

School:_____ ***Home Room Teacher:***_____ ***Grade:***_____

Student: *Last Name*_____ *First Name:*_____ *MI*_____

SEX: M F *DOB:* ____/____/____ *Current Age:*_____ *Child's SSN:*_____

RACE: ☐ *Asian* ☐ *Black* ☐ *Native American* ☐ *Pacific Islander* ☐ *White* ☐ *Other* ***ETHNICITY****: Hispanic* ***Y*** ***N***

Address_____***City***_____***State***_____***Zip***_____

Parent/Guardian: Last Name:_____ ***First Name:***_____ ***MI:***_____

Parent/Guardian Home Phone:_____ ***Cell Phone:***_____

Please CHECK YES or NO to ALL questions below for the STUDENT. The Nurse giving the vaccination will review the information on vaccination day.	**YES**	**NO**
1. Has your child had a history of immediate severe allergic reaction (anaphylaxis) to any of the components of TDAP (i.e. tetanus, diphtheria, or pertussis vaccines) or to any combination vaccine containing TDAP components?		
2. Has your child had a history of encephalopathy (e.g., coma, prolonged seizures) within 7 days of administration of a pertussis-containing vaccine that is not attributed to another identifiable cause?		
3. Has your child had a history of Arthus-type hypersensitivity reaction following prior tetanus vaccination?		
4. Does your child have a current progressive neurologic disorder, uncontrolled epilepsy, or progressive encephalopathy?		
5. Does your child have a history of severe allergic reaction (anaphylaxis) to latex?		
6. Has your child developed Guillain-Barre syndrome (GBS) within 6 weeks after a previous dose of a tetanus toxoid-containing vaccine?		
7. Does your child have an acute moderate-to-severe illness, with or without fever; vaccination? If yes, vaccination should be deferred until illness has been resolved.		
Please list any allergies:		
Additional Notes:		

Request for Administration of TDAP Vaccine for the above named recipient: I will receive information about the vaccine and special precautions on the Vaccine Information Sheet prior to my child receiving the vaccine and on the day of vaccination. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent that the vaccine be given to the person above of whom I am parent or legal guardian and acknowledge that no guarantees have been made concerning the vaccine's success. I hereby release Northeast Tennessee Regional Department of Health, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.

I understand that this document will be given to and retained by the public health department. I give my permission for my child's school to retain a copy if needed.

I acknowledge that I have been given the Department of Health's Notice of Privacy Practices.

I give consent to bill TennCare or private insurance for the service provided.

This Consent Form is valid for administration of TDAP vaccinations for six (6) months. I understand that I should report any changes of the above information to the health department prior to vaccination.

_____ _____

Parent / Guardian Signature Date

PLEASE COMPLETE BACK OF FORM

VACCINE FOR CHILDREN (VFC) ELIGIBILITY

The following information is required for federal funding purposes for the Vaccine for Children Program:

PARENTS: Please answer questions below

Is your child an American Indian or Alaska Native? YES NO

Does your child have Private Medical Insurance? YES NO
*If yes, please complete the insurance information below.

Does your insurance cover the TDAP vaccine? YES NO

Name of Private Insurance Company: _____

Address of Insurance Company: _____

_____

Policy Number: _____ Group No: _____

Name of Insured: _____ Insured's SSN: _____

Insured DOB: _____ Insured's Phone No: _____

Insured's Employer: _____ Relationship to Insured: _____

Does your child have TennCare? YES NO
*If yes, please complete the insurance information below.

TennCare ID#_____ BlueCare ☐ UnitedHealthcare ☐

AREA FOR OFFICIAL USE ONLY

#1 Manufacturer: ☐ _____ **VIS Date: 8/06/2021**

Lot number:

Site administered: ☐**Right Deltoid** ☐**Left Deltoid** ☐

Date Given: _____ **Signature**_____

Signature above indicates immunization given according to PHN Protocol