



Public Health
Prevent. Promote. Protect.

Page County Public Health
1208 W. Nishna Rd., Suite B
712-246-2332

DTP PERTUSSIS DT Td TDAP
CONSENT FORM

Date Administered:	
Vaccine Manufacturer	
Vaccine Lot #	
Site of Injection	
Administrator Signature & Title	

Full Name: _____ Age: _____

Birth date: _____ Soc Sec: _____ Phone: _____

Address: _____

City: _____ Zip Code: _____ County: _____

Physician: _____ City: _____

Date of Last tetanus vaccine: (effective for 8 – 10 years) _____

Allergies: _____

The doctor or clinic may keep this record in your medical file or your child's 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 the title of the person who gave the vaccine and the address where the vaccine was given.

I have read or have had explained to me the information about diphtheria, tetanus (lockjaw), and Pertussis (whooping cough) disease and DTP, Pertussis, DT, Td and Tetanus vaccines. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the DTP, Pertussis, DT, Td, and Tetanus vaccines and ask that the vaccine checked below be given to me or to the person named below for whom I am authorized to make this request.

Signature _____ Date _____

OFFICE USE:

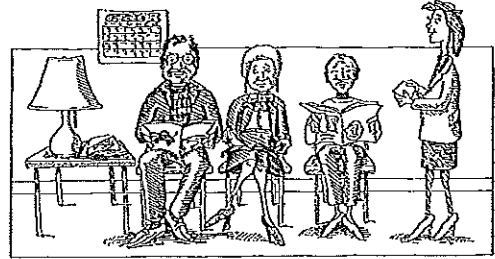
Pay Source: PP or Business to Bill: _____

7.6.11

Patient name: _____

Date of birth: ____/____/____
(mo.) (day) (yr.)

Screening Questionnaire for Adult Immunization



For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have allergies to medications, food, or any vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have cancer, leukemia, AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had a seizure, brain, or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you received any vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Did you bring your immunization record card with you? yes no

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.