2016-2017 REQUIRED Tdap Vaccine Consent Form

PLEASE COMPLETE All THE INFORMATION BELOW (Unreadable and incomplete forms will not be accepted)

BEFORE ENTERING 7TH GRADE ALL STUDENTS ARE REQUIRED TO HAVE THEIR TDAP (Tetanus, Diphtheria, Pertussis) VACCINATION

Full, Legal Name of Student (*First Name Middle Initial. Last Name)* PLEASE PRINT		**Name of School**	
Parent/Guardian Name (*First Name Middle Initial. Last Name)*	**Relationship to Student**	**Grade**	
Address	**Email Address**	**Birth Date** (month / date / year)	**Age** **Sex**
City	**Zip Code**	**Home Phone #**	**Cell Phone #**
Demographic Information: (Circle one) White American Indian/ Native Alaskan Black Asian Hispanic Other			

Insurance ☐ **Medicaid** ☐ (Prestige, UHC Community, StayWell, & Sunshine) **Please fill out the following questions pertaining to your child's Health Insurance:**	
Insurance Company:	**Member ID:**
Policy Holder's Name:	**Policy Holder's Date of Birth:**
The current health care laws require us to bill your insurance company for the vaccine. You will not be billed, and there will be no co-pay or deductible due. The service is offered at no cost to you! **As always, the information you provide remains confidential.**	☐ **MY CHILD DOES NOT HAVE HEALTH INS**

Questions: Check **YES** or **NO** for the questions below. Incomplete forms **WILL NOT** be accepted. A signature is **REQUIRED,** so please be sure to sign the bottom of the consent form.

Yes	No	
☐	☐	**1.) Do any of the following apply to your child?** ***(If you answer YES, your child cannot receive Tdap (Tetanus, Diphtheria, Pertussis) unless approved by your child's doctor)***

- **Allergy to Latex or Latex products**
- **Life threatening reaction(s) to a vaccine in the past**
- **Does this child have an unstable neurological disorder such as Epilepsy or seizures?**
- **Has had Guillain-Barre syndrome (very rare)**

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S PEDIATRICIAN OR CALL HEALTHY SCHOOLS AT 1-800-566-0596 TO SPEAK TO A NURSE.

I have received, read, and understand the CDC Vaccine Information Statement for the Tetanus, Diphtheria, and Pertussis- Tdap Vaccine). I have read these documents and understand the risk and benefits of the Tdap vaccine. I give permission to Healthy Schools and their administrators to give my child the vaccine in my absence, to communicate with other healthcare providers, as needed, and for data entry, billing and storage according to Florida Department of Health policies, to assure optimal healthcare for my child.

☐ **YES, I want my child to receive the Tdap (Tetanus, Diphtheria, Pertussis) Vaccination**

Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date
_____	_____	_____

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

VIS CDC IV Tdap **LOT Number:** **EXP Date:** RN #_____ Date:_____	VIS CDC IV Tdap **LOT Number:** **EXP Date:** RN # _____ Date: _____