Student name: _____ Grade: ____ Date of birth: _____ Age: _____
(Print Last Name, First Name)

California State-Mandated Tdap (Pertussis) Booster

Screening Questionnaire/Consent Form for Child/Teen Immunization

For parents/guardians: Please attach a copy of your child's Immunization Record and answer the following questions. If you answer "yes" to any question below, your child will not be vaccinated at our clinic. Please contact your healthcare provider or school nurse at 310-842-4200, ext 3331 if you have any questions.

Has your child:	Yes	No
Had a life-threatening allergic reaction to previous DTP, DTap, DT, or Td vaccines?	☐	☐
Been diagnosed with Guillain-Barré syndrome within 6 weeks of a prior tetanus vaccine?	☐	☐
Received any live vaccinations (e.g. Flumist, MMR, Varicella) in the past 4 weeks?	☐	☐
Taken cortisone, prednisone, other steroids, anticancer drugs, or had radiation treatments in the past three months?	☐	☐
Had a life-threatening allergy to latex?	☐	☐
Had a seizure disorder or other central nervous system problems?	☐	☐
Had a diagnosis of cancer, leukemia, AIDS, or any other immune system problem?	☐	☐
FOR FEMALES: Is your daughter currently pregnant or nursing?	☐	☐

I have read the Vaccine Information Statement and give consent for my child (named above) to receive the Tdap vaccine. I understand that my child's immunization history will become part of the California Immunization Registry, which can be viewed by other healthcare professionals.

Parent/Guardian Signature: _____ Date: _____

Optional: I give consent for my child to receive an age-appropriate dose of Tylenol/Acetaminophen to relieve discomfort associated with the Tdap vaccine.

Parent/Guardian Signature: _____ Date: _____

FOR SCHOOL NURSE ONLY

Date Tdap administered: _____ By: KLA DC _____ IM: LD RD

Acetaminophen administered PO: None ☐ 325mg ☐ 650mg ☐