AGE:

THE CITY UNIVERSITY OF NEW YORK
IMMUNIZATION CONSENT FORM FOR TDAP VACCINATIONS

COLLEGE	TELEPHONE	EMERGENCY CONTACT#	
LAST NAME		FIRST	M.I.
□ MALE □ MTF □ FEMALE □ FTM	MOTHER'S MAIDEN NAME	DATE OF BIRTH Month Day Year	
ADDRESS	APT.	CITY	STATE / ZIP

SCREEN A

ALL INFORMATION PROVIDED WILL BE KEPT CONFIDENTIAL.

PLEASE CHECK THE APPROPRIATE BOX (ES) BELOW

1. Do you have health insurance? □ YES □ NO
2. If yes, who is your insurance carrier?

□ Health Care Exchange Plan □ Sponsored by Parent/Guardian
□ Medicaid □ Uninsured
□ Private (ex. Aetna, BlueCross, HIP)_____
□ Underinsured □ Other: (specify)_____

Covered by:
□ Spouse
□ Domestic Partner
□ Employee

SCREEN B

	CIRCLE ONE	
1. Are you feeling sick with anything other than a cold today?	YES	NO
2. Do you have allergies to medications, latex or any vaccine?	YES	NO
a. If so, please list: _____		
b. What type of allergic reaction did you have to the food, meds or vaccine?_____		
3. Do you suffer from any seizures, epilepsy or any immune system prob	YES	NO

TDAP IS NOT RECOMMENDED FOR PREGNANT WOMEN

1. What was the date of your last menstrual period? _____		
2. Are you pregnant or is there a chance you could be pregnant now?	YES	NO

Interviewed by: _____

CONSENT

I have read the information contained in the Vaccine Information Statement about the disease(s) and the vaccine(s). I have had a chance to ask questions which, if any, were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me or to the person named for whom I am authorized as parent, guardian, or long term custodian to make this request.

Yo he leido la Declaracion de Vacunas acerca de la(s) enfermedad(es) y la(s) vacuna(s). He tenido la oportunidad de hacer preguntas las cuales, si hubo algunas, fueron contestadas a mi satisfaccion. Creo que comprendo los beneficios y riesgos de la(s) vacuna(s) y pido que me den la(s) vacuna(s) indicada(s) mas abajo a mi o a la persona nombrada por quien estoy autorizado(a) como padre, guardian, o cuidador por largo tiemp[o para hacer esta peticion.

PATIENT/PARENT SIGNATURE **DATE**

FIRMA DEL PACIENTE/PADRE _____ **FECHA** _____

OFFICE USE ONLY

Vaccine	Dose #	Dosage	V.I.S.	Injection Site	Manufacturer	Lot #	Expiration Date
TDAP				LUA/RUA			

Innoculator Signature: **Date:**