**North Atlanta Pediatrics**

***Tdap Consent Form for Parents***

1. **Please Print**
2. **Complete all areas of form**
3. **Signature required at bottom of Form**
4. **Payment Required at date of service – we will not bill your insurance**

**This Box for Office Use Only:**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tdap Vaccine Paid by \_\_\_Cash \_\_\_ Credit Card \_\_\_ Check \_\_\_\_\_\_\_\_ Check #

Amt Paid \_\_\_\_\_\_\_\_\_\_ Child’s Acct # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Last Name | First Name | Middle |
| Date of Birth | Age | \_\_\_Male\_\_\_Female |
| Address | City | State | Zip |
| Home phone | Cell phone | Date |

|  |  |  |
| --- | --- | --- |
| Please check appropriate box: | Yes | No |
| 1 | Are you allergic to thimerosal, latex rubber or formaldehyde? |  |  |
| 2 | Are you sick with a fever? |  |  |
| 3 | Do you have a bleeding disorder (hemophilia or thrombocytopenia, or an anticoagulant therapy? |  |  |
| 4 | Have you ever had a serious reaction to a previous dose of Diptheria,Tetanus, Pertussis Toxoid Vaccine (DTP)?  |  |  |
| 5 | Are you pregnant or nursing? |  |  |
| 6 | Did you have the vaccines required for school as a child? |  |  |
| Explain any yes answers on questions 1 through 6: |

I have read the Vaccine Information Statement which includes the indications, precautions, possible adverse reactions or complications related to the vaccine. I hereby consent to and authorize North Atlanta Pediatrics to administer this vaccine.

I hereby release North Atlanta Pediatrics and its employees from any and all liabilities in connection with this vaccine and its administration to me.

**Signature of person receiving the vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**To be completed by nurse administering the vaccine:**

* All yes answers have been addressed
* Vaccine and lot # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Location given \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Data has been put into GRITS (Must be added manually – Add patient as needed)
* Nurse Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_