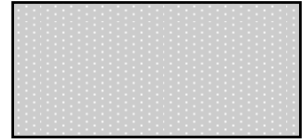


CLEVELAND COUNTY HEALTH DEPARTMENT

TDAP CONSENT FORM



_____		_____	
Name		Sex	Date of Birth
Race			
_____		_____	
Address		Social Security Number	
_____		_____	
City, State	Zip	Daytime Telephone Number	

By signing below, I give permission to receive the Tdap vaccine (no charge). I understand that I need to receive this vaccination only once and that it serves as the regular tetanus booster. I have read the *Vaccine Information Statement* for the Tdap vaccine and have had my questions answered.

Please answer the following:

Allergies : YES___ NO___ If yes, list allergies: _____

Any latex allergies? YES___ NO___ _____

I give my permission to receive the vaccine: _____
Self / Parent/Guardian Signature

Please check all the following statements that apply: Note: This information is required for federal funding purposes. It will not prevent your child from receiving the vaccine free of charge.

- I am/My child:
- Is enrolled or eligible to be enrolled in the Medicaid Program
 - Is not insured - No Medical Coverage
 - Is American Indian or Alaskan Native (as defined by the Indian Health Service Act)
 - Is Underinsured, has insurance, but insurance **does not** cover immunizations

*** MUST BE BETWEEN THE AGES OF 11-64 YEARS OF AGE***

PLEASE BRING THIS COMPLETED CONSENT FORM TO THE TDAP DRIVE-IN CLINIC AT THE CLEVELAND COUNTY HEALTH DEPARTMENT 315 EAST GROVER STREET, SHELBY NC, 28150

<u>Health Department Documentation Only:</u>		
5/02/09	_____	Rt. Del / Lt. Del
	Lot #, Manufacturer	

	Nurse Signature	