Marinette County
Health and Human Services – Public Health
2500 Hall Avenue - Marinette, WI 54143
Phone: 715-732-7670 Fax: 715-732-7646
Toll Free Phone: 1-888-732-7549
www.marinettecounty.com

Public Health
Prevent. Promote. Protect.
Marinette County

TDaP - VACCINE CONSENT FORM

Student Name (Last, First, Middle initial) please print			Male Female
Date of Birth	Age	Parent/Guardian Name	Telephone Number ( )
Address	City	County State	Zip Code
Does your child have? ☐ Badger Care ☐ No Health Insurance ☐ Insured, Vaccines Covered ☐ Insured, Vaccines Not Covered ☐ Native American Heritage			
School	Teacher	Grade	

Please Circle Yes or No

Does the child have any allergies to medications, food, a vaccine component or latex? List:_____	YES	NO
Has the child had a serious reaction to a vaccine in the past?	YES	NO
Has the child had a health problem with lung, heart, kidney, or metabolic disease (e.g. diabetes), asthma or a blood disorder? Is he/she on long-term aspirin therapy?	YES	NO
Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	YES	NO
Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	YES	NO
In the past 3 months, has the child taken medications that weaken his/her immune system, such as cortisone, prednisone, other steroids, anticancer drugs or had radiation treatments?	YES	NO
In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	YES	NO
Is the person to be vaccinated pregnant or is there a chance that she could become pregnant in the next month?	YES	NO
Has the child received any vaccination during the past 4 weeks? List: _____	YES	NO

CONSENT FOR VACCINATION: I have read, or have had explained to me, the Vaccine Information Statements for the vaccines listed above (www.immunize.org/vis). I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the selected vaccines, if indicated, be given the person named above for whom I am authorized to make this request. Marinette County Health Department will bill Medical Assistance/BadgerCare if the child is covered by those programs. I understand that a record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) and with other health care providers directly involved with the vaccinated person's care. This consent form authorizes the administration of multiple doses of a vaccine, if medically indicated. This consent form will expire after the last vaccination is given in a vaccine series.

Guardian Signature: _____ **Date:** _____

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FOR OFFICE USE:

Is the child well today? YES NO

TDAP

Route IM Body site RD RV LD LV Dose 1

Manufacturer_____ Lot No:_____

Signature/Title of person administering vaccine _____

Date vaccine administered_____

WIR ENTRY_____ **BILLED**_____