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 ***Office of Student Health Services***

 *Tetanus/Diphtheria/****Pertussis (Tdap)***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student’s DOB/ID Number \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_

Please answer the following questions, and describe any yes answers in the space below the list of questions.

Are you allergic to ANY medications? ………………………………………………….. Yes No

Have you had **any** reaction to a previous vaccination containing diphtheria, tetanus,

or **pertussis**, including DTP as a child?...............................................................................Yes No

Do you have an illness that suppresses the immune system?.............................................Yes No

Are you allergic to Latex?.................................................................................................... Yes No

Have you ever had convulsions or a brain injury? ……………………………………….. Yes No

If female, are you pregnant or breastfeeding? LMP: ………………………..................... Yes No

Do you have a moderate illness or fever at the present time?............................................ Yes No

Have you ever been diagnosed with Guillain-Barre Syndrome?………………………….. Yes No

I have received and read the Centers for Disease Control (CDC) Vaccine Information Sheet: “Tetanus, Diphtheria (Td) or Tetanus, Diphtheria, Pertussis (Tdap) Vaccine-What You Need To Know”, dated 2/24/2015, and have had the opportunity to ask questions. I understand the risks and benefits of the vaccine and consent to vaccination with the Tetanus, Diphtheria, **Pertussis** vaccine at this time. I also agree to remain in the Health Center for **15 minutes** following my injection.

 I agree to hold Coastal Carolina University (CCU) Student Health Services and all of its employees harmless with regard to this vaccine or its administration. IT IS MY INTENTION BY THIS INSTRUMENT TO EXEMPT AND RELIEVE CCU BOARD OF TRUSTEES, ITS INSTRUCTORS, AGENTS, OR EMPLOYEES FROM LIABILITY FOR PERSONAL OR BODILY INJURY, OR WRONGFUL DEATH CAUSED FROM THE ADMINISTRATION OF THE TETANUS, DIPHTHERIA, **PERTUSSIS** VACCINE. I hereby CONSENT to receive this vaccine.

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Parent/Legal Guardian if under 18 y.o.)

Witness Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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For Clinic Use Only:

Temperature: \_\_\_\_\_\_\_\_\_ Vaccine Manufacturer: \_\_\_\_\_\_\_\_\_\_ Lot #: \_\_\_\_\_\_\_\_ Exp. Date: \_\_\_\_\_\_\_\_\_

Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injection Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date administered:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_