

Name: _____ First: _____ Date of birth: _____ Age: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: (____) _____ cell: (____) _____ Physician: _____

ADULT ADACEL VACCINE

Because of the increased risk of severe or fatal pertussis to infants under 12 months of age, the ACIP and CDC highly recommends a dose of Tdap for all persons who have or who anticipate having close contact with an infant less than 12 months of age.

	Yes	No
1. Do you have allergies to latex, or thimerosal?		
2. Do you have moderate to severe acute illness today?		
3. Have you had a tetanus shot in the past two years?		
4. Have you had a serious allergic reaction to vaccine components?		
5. Have you ever had coma, prolonged seizures, not attributable to an identifiable cause within 7 days of administration of a pertussis vaccine?		
6. Have you had Guillian Barre' Syndrome?		
7. Have you had progressive neurological disorder, such as uncontrolled epilepsy?		
8. Have you had history of Arthus hypersensitivity reaction to a tetanus toxoid-containing vaccine administered less than 10 years previously?		
9. Are you pregnant?		
<u>Did you bring your immunization card with you?</u>		

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

Consent:

I have read or have had explained to me the Vaccine Information Statement (VIS) about Adacel vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that it be given to me. I received a copy of the Vaccine Information Statement and Sanofi Pertussis Information Sheet. The child I am protecting is _____ D.O.B. _____ Relationship: _____

 Signature of person to receive vaccine Print name of person to receive vaccine Date

Manufacturer	Date given	Lot #	Exp. Date	Dose	Site	VIS sheet	Med. Assist

B.P. prior	Time

MEDICAL GROUP PAID: \$50 _____
 Dr. Pediatrician
 Tax ID#

5000 S. Pertussis Road #234
 Anaheim Hills, Ca 92807
 Ph:(714) 555-1212 Fax:(714) 555-1234

1820 Immunization Ave #230
 Corona, Ca 92881-3147
 Ph:(951) 555-5944 Fax:(951) 555-7480