Consent for Tdap (Adacel® or Boostrix®) or Td Vaccine - School Clinics

Vaccine Consent Form

Student Last Name: _____ Student First Name: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Doctor: _____ School: _____

YES - I agree to be vaccinated against:
Tetanus, Diphtheria, and Pertussis (Tdap)
or
Tetanus, Diphtheria (Td)

_____ _____ _____
Signature Print Name Date

☐ I have read or had explained to me information about the Tdap or Td vaccine. I have had the chance to ask questions, which were answered to my satisfaction.

The suspension process will be started once the school clinics are over. Please call the Health Unit Vaccine Preventable Disease Team at 519-426-6170 Ext. 3214 if you have questions or concerns.

Tetanus, diphtheria and pertussis (Tdap) or Tetanus, diphtheria (Td) given and Family Physician's office or Hospital Emergency Department:

Date Given: _____ Doctor or Medical Facility: _____

OFFICE USE ONLY

☐ Panorama Nurses Signature: _____

Vaccine	Dose	Route	Site	Date	Time	Lot #

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Simcoe, ON N3Y 4L1
519-426-6170 or 905.318.6623

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