Consent for Tdap (Adacel) or Td Vaccine

Student Surname: _____ Student First Name: _____

☐ Male ☐ Female Date of Birth _____ 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. 3220, 3222 or 3227 if you have questions or concerns.

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

Date Given: _____ Doctor or Medical Facility: _____

For Office Use Only

Vaccine
☐ Tdap
☐ Td

Dose
☐ 0.5 mL

Date _____ Time _____ Lot# _____

Route
☐ Im

Site
☐ Rt Deltoid
☐ Lt Deltoid

Nurse's Signature _____

Simcoe: P.O. Box 247, 12 Gilbertson Drive, Simcoe, ON N3Y 4L1 **T**: 519-426-6170/905-318-6623 **F**: 519-426-9974
Caledonia: 282 Argyle Street South, Caledonia, ON N3W 1K7 **T**: 905-318-5367 **F**: 905-765-8905
Dunnville: 117 Forest St. E., Dunnville ON N1A 1B9 **T**: 905-318-6623 **F**: 905-774-1538