



# Student Consent Form for TDaP or TD Shot

### To get vaccinated:

Has your child ever had a life-threatening reaction after receiving a dose of Diphtheria, Tetanus, or Pertussis (DTP or DTaP)? YES NO

Is your child allergic to any vaccine components? YES NO

Any YES answer indicates *no vaccination is best.*  
**Contact your health care provider for a medical exemption.**

### To get TDaP or TD:

Has your child had seizures or coma within 7 days after a dose of DTP or DTaP? YES NO

Does your child have an unstable neurological disorder? Such as Epilepsy or seizures? YES NO

Any YES answer indicates that **TD is the best option and a medical exemption will be required.**

All No answers indicate that **TDaP is the best option.**

\* If you have any questions or concerns about your child receiving the 7<sup>th</sup> Grade Booster shot (TDaP/TD), Contact your health care provider or the Flagler County Health Department at 386.437.7350, ext.2226, Bonnie Welter, RN Or ext. 2250, Sara Bruce, RN, School Health.

Child's Last Name \_\_\_\_\_ Child's First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ RACE \_\_\_\_\_ SEX \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone / Contact # \_\_\_\_\_

Please **circle** if you have the following? **No Insurance** **Insurance** **Medicaid** **Medicare #** \_\_\_\_\_

### PARENTS / GUARDIANS:

I, \_\_\_\_\_ have the following relationship with the person named above, and have the legal authority  
 (Print name of consenting adult) pursuant to s.743.0645, F.S., to consent to this vaccine administration.

\_\_\_ Father \_\_\_ Stepfather \_\_\_ Grandfather \_\_\_ Adult Brother \_\_\_ Adult Uncle \_\_\_ Court Order  
 \_\_\_ Mother \_\_\_ Stepmother \_\_\_ Grandmother \_\_\_ Adult Sister \_\_\_ Adult Aunt \_\_\_ Legal Guardian

I have read the appropriate TD or TDaP Vaccine Information Statement 11/18/08 and I understand the benefits and risks. By signing this consent, I am authorizing the Flagler County Health Department (FCHD) Staff to administer the TD or TdaP Vaccine to the person designated on this form **in my absence**. I also understand that by my signature below I acknowledge receipt of the notice of privacy rights, and if applicable, I assign the benefits for services to FCHD and authorize FCHD to submit a claim to my insurance company for payment on my behalf. If my insurance denies the claim, I understand I will not be responsible for payment of this service.

**Signature of consenting adult:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **CLINIC USE ONLY: (circle) TD or TDaP**

**Manufacturer:** \_\_\_\_\_ **Lot #** \_\_\_\_\_ **Exp. Date:** \_\_\_\_\_

**Form review (initials)** \_\_\_\_\_ **Route:** \_\_\_ IM **Site:** \_\_\_ RD \_\_\_ LD  
**Administered by (initials):** \_\_\_\_\_ **Title** \_\_\_\_\_ **Date:** \_\_\_\_\_