Huron Perth Public Health

Consent Form
Tdap - Adacel/Boostrix

Last Name: _____ First Name: _____

Address: _____ City: _____

Postal Code: _____ Phone Number: _____

Date of Birth: _____ / _____ / _____ _____ School: _____

YYYY MM DD Age

Please read the attached fact sheet and complete the consent information below.

Student's Personal Health Information – ***please explain any yes answers below***	YES	NO
Have you received Adacel or Boostrix vaccine recently due to an injury or cut, for travel, a new job, or for volunteer purposes?	☐	☐
Have you ever had a reaction to any immunization in the past?	☐	☐
Do you have any allergies?	☐	☐
Are you feeling sick today?	☐	☐
Do you have any serious health problems?	☐	☐
Are you taking any medication?	☐	☐
Is there any chance you might be pregnant?	☐	☐
Have you ever developed Guillain-Barré Syndrome within six weeks of a past immunization?	☐	☐
Please explain any "yes" answers:		

I have read or had explained to me the information about this vaccine. I have had the chance to ask questions, and I understand the answers provided to me. I consent to receive the **Adacel/Boostrix** vaccine. I am aware that personal health information collected on this form may be released, when requested, to my physician, other health units, and other organizations as specified by the ***Personal Health Information Protection Act***. This is done to ensure that vaccines are administered at the right time and are not given more often than needed.

YES. I consent to receive this vaccine.

Signature_____ Date _____

Please print your name _____

If client is unable to consent for themselves, are you the custodial parent or legal guardian? ☐ Yes ☐ No

*This information is collected under the authority of the **Health Protection and Promotion Act** and the **Immunization of School Pupils Act** for the purpose of maintaining an immunization record. For more information on this collection, contact the Public Health Manager toll-free at 1-888-221-2133.*

****Please bring this completed form with you on the day of the clinic****

FOR NURSE'S USE ONLY						
Vaccine	Dose	Site	Lot Number	Date Given	Time Given	Given By
☐ Adacel ☐ Boostrix	0.5ml	L or R deltoid				