2015--2016 **Tdap** VACCINATION RECORD

Information about person to receive vaccine ***(please print)***

Last Name:_____ First Name: _____ Age: _____ Sex: ___ M ___ F

Address: _____ City _____ Zip Code _____ Date of Birth _____

Phone number _____ Grade _____ School _____

For the child being vaccinated - check any that apply **(Check here if none apply)** ____

____ Enrolled in Medica Please provide Medicaid # _____ ____ American Indian or Alaskan Native

____ Does not have health insurance ____ Health insurance DOES NOT pay for vaccines

The South Dakota Immunization Information System (SDIIS) is an automated system to document vaccinations given in South Dakota. SDIIS will give parents access to their child's immunization record from any participating South Dakota provider. SDIIS also allows providers to send reminder notices regarding needed immunizations. Health care providers, health care facilities, federal or state agencies, welfare agencies, school or family day care facilities may have access to this information in accordance with applicable HIPAA Privacy Act standards and requirements. Immunization records remain confidential, and any person who fails to protect the confidentiality of this information is guilty of a Class 1 misdemeanor. If you choose NOT to have your/your child's immunization record shared with other providers, you may request a refusal form.

Please answer the following health screening questions	**Yes**	**No**	**Don't Know**
1) Is the child sick today?	____	____	____
2) Does the child have allergies to medications, food, a vaccine component, or latex?	____	____	____
3) Has the child ever had a serious reaction to a vaccine in the past?	____	____	____
4) Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problem?	____	____	____

Children who have received a prior dose of Tdap do not need to be re-vaccinated at this time.

CONSENT for Vaccination

I have been provided a copy of and have read or have had explained to me the information about Tetanus, Diphtheria, Pertussis diseases and the Tdap vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and the risks of the vaccine and ask that the vaccine be given to the child above for whom I am authorized to make this request.

Signature (Parent or guardian if a minor) _____ Date _____

If you are completing this for your child and do not plan to attend the clinic, please provide a phone number where you could be reached on the day/time of the clinic

_____

for office use only **Tdap**

Date/Time	Vaccine Manufacturer	Vaccine Lot number	Route	Site **Circle**	Date of VIS Publication	Signature of person administering vaccine
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The Department of Health Notice of Privacy Practices can be found on the following website: http://doh.sd.gov/documents/HIPAANotice.pdf

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