



Place sticker:

Student address: _____

Student name: _____

UIN: _____

DOB: _____

Age: _____

Telephone: _____

Current medications

Please list your current medication. Include prescription medication and over the counter medications/drugs:

Allergies

Please list any allergies that you may have:

Medical history

Before receiving an injection, I will ask questions of the provider if I have any.

I will inform the provider of any allergies BEFORE receiving the vaccine.

I do not have an acute illness or infection.

I have received and read the Vaccine Information Statement on the Td/Tdap vaccine, including contraindications and side effects.

I will inform the provider of any allergies, seizures, Guillain-Barre Syndrome, coma, or encephalopathy.

I am not on blood thinners, anticoagulants or have a bleeding disorder.

I am not older than 64, if no then Boostrix will be given.

I understand that I should report any adverse reactions to Health Services at (217) 206-6676.

I am not pregnant or breast feeding.

I believe I understand the benefits and risks of the vaccine(s) and request that it be given to me.

I agree to remain in the Health Services Clinic for 15-20 minutes following injection to be observed for any sign of adverse reaction.

Student Signature _____ Date: ____/____/____

HEALTH SERVICES USE ONLY

VIS form given: Yes No VIS form date: ____/____/____ VIS given by: _____

Td/Tdap Administration

Has advice been given about the requirements for 3 doses (a full course)? Yes No

Has patient been advised of side effects (inflammation at vaccine site and slight malaise for a day or two)? Yes No

(Tetanus Diphtheria Pertussis)

1. Name of vaccine: _____ Lot number: _____ Expiration date: ____/____/____

Route: IM Site of vaccination: RT deltoid LT deltoid Nurse Signature: _____ Date: _____

(Tetanus Diphtheria)

2. Name of vaccine: _____ Lot number: _____ Expiration date: ____/____/____

Route: IM Site of vaccination: RT deltoid LT deltoid Nurse Signature: _____ Date: _____

(Tetanus Diphtheria)

3. Name of vaccine: _____ Lot number: _____ Expiration date: ____/____/____

Route: IM Site of vaccination: RT deltoid LT deltoid Nurse Signature: _____ Date: _____