MHI Health
Mile Hi Immunizations & Healthcare Services

MILE HI IMMUNIZATIONS, LLC
283 Columbine Street #150, Denver, CO 80206
303-374-3374 phone 303-374-8656 fax

2009 TETANUS/DIPHTHERIA CONSENT FORM

This vaccine is recommended for people age 65 and over every 10 years.

NAME LAST (one character per box) NAME FIRST MIDDLE INITIAL

STREET ADDRESS

CITY STATE ZIP

SEX DATE OF BIRTH AGE PHONE

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Precautions & Contraindications: Please Shade-In "Yes" or "No" for each question.

Have you ever had a Tetanus/Diphtheria shot before?	YES ☐ NO ☐
If you have received a Tetanus/Diphtheria shot, was it less than 10 years ago?	YES ☐ NO ☐
Are you pregnant or lactating (company policy does not allow us to vaccinate pregnant or lactating women)?	YES ☐ NO ☐
Have you ever had an adverse reaction to another vaccine?	YES ☐ NO ☐
Please list the adverse reaction _____	
Do you have a past history of Guillain-Barre syndrome?	YES ☐ NO ☐
Do you have any hypersensitivity to any component of the vaccine, including thimerosal?	YES ☐ NO ☐
Do you have a history of sensitivity to latex? (refers to gloves and rubber stopper)	YES ☐ NO ☐
Do you currently have a fever or respiratory illness or any other type of infection?	YES ☐ NO ☐

Adverse reactions may include redness, warmth, swelling, tenderness, rash, systemic-malaise, slight fever, pain, low blood pressure, nausea, hives, swelling of the mouth, difficulty breathing, shock and very rarely, anaphylactic reactions resulting in death.

BASED UPON YOUR RESPONSES TO THE ABOVE QUESTIONS, THE NURSE MAY REFER YOU TO YOUR PHYSICIAN FOR YOUR INJECTION.

For OBSERVATION: Please remain on the premises for 10 minutes following vaccination. If you leave the area, you are doing so against medical advice. Your safety is our primary concern.

THIS SECTION TO BE COMPLETED BY NURSE

(Please note, if one of the following is NOT a clear choice, shot must be paid for at time of service):

Please Choose One: Customer Employee

If Applicable, Please Choose One: Cash Check Bill Company Pd to Store

SITE: ☐LD / ☐RD NURSE'S INITIALS_____

LOT #: CLINIC DATE: / / 2009