



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

2011 TETANUS/DIPHTHERIA/ PERTUSSIS CONSENT FORM

This vaccine is recommended for people 11 – 64 every 10 years.

NAME LAST (one character per box)										NAME FIRST										MIDDLE INITIAL		
STREET ADDRESS																						
CITY															STATE			ZIP				
SEX		DATE OF BIRTH				AGE			PHONE													
		/				/			-				-									
M / F		M M / D D / Y Y Y Y																				

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

- | | | | | |
|--|-----|-----|-----|-----|
| 1. Have you ever had a Tetanus/Diphtheria shot before?..... | YES | ___ | NO | ___ |
| 2. If you have received a Tetanus/Diphtheria shot, was it less than 10 years ago?..... | YES | ___ | NO | ___ |
| 3. Are you pregnant or lactating (policy does not allow vaccination of pregnant or lactating women)? | YES | ___ | NO | ___ |
| 4. Have you ever had an adverse reaction to another vaccine? | YES | ___ | YES | ___ |
| Please list the adverse reaction _____ | | | | |
| 5. Do you have a past history of Guillain-Barre syndrome? | YES | ___ | NO | ___ |
| 6. Do you have any hypersensitivity to any component of the vaccine, including thimerosal? | YES | ___ | NO | ___ |
| 7. Do you have a history of sensitivity to latex? (refers to gloves and rubber stopper) | YES | ___ | NO | ___ |
| 8. 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.****

NOTE: If you are between the ages of 11-18 and have not had a tetanus vaccine in the past 5 years you may receive a Tdap vaccine. If you are between the ages of 19 – 64 and have not had a tetanus vaccine in the past 2 years, you may receive a Tdap vaccine.

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

I have read the adverse reactions listed above associated with the Tetanus vaccine and I am aware that a copy of the vaccine manufacturer's drug information sheet is available at the CDC website. Furthermore, I have also had an opportunity to ask questions about this immunization. I believe that the benefits outweigh the risks and I assume full responsibility for any reactions that may result. My medical record may be shared with my physician/insurance. I waive and release any and all claims I, or anyone claiming by or through me, now have or may hereafter acquire against Mile High Health Solutions, the clinic site sponsor and their respective parent, subsidiaries, and each of their directors, officers, employees, and agents for any and all damages or injuries arising out of or related to the receipt of the Tetanus/Diphtheria shot, including, without limitation, if I, the person named below for whom I am authorized to make this request, contract Tetanus, other related diseases, or suffer any other damages or adverse reactions, including death, following administration of this Tetanus shot. I am requesting that the immunization be given to me or the person named below for whom I am the legal guardian.

X _____ (Signature/Legal Guardian) Date: _____

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: / / 2 0 1 1