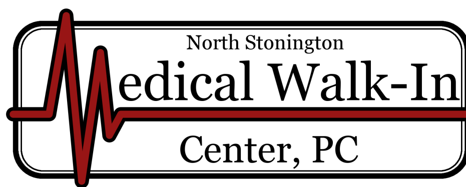
82 Norwich-Westerly Road
North Stonington CT 06359



Phone: (860)599-2469
Fax : (860)599-2830

Tetanus, Diptheria, Pertussis Vaccine Authorization

Name:____ Date of Birth______________________

Street Address:____

City:_______________________________ State:______________ Zip:___________________

Telephone:____________________________________ SSN:___________________________

Have you ever had a reaction to Tetanus, Diphteria, or Pertussis shots? Yes / No

Have you ever had Guillain Barre, Encephalopathy, or Brachial Neuritis? Yes / No

Do you have a Neurological condition? Yes / No

Do you have Arthus Type Sensitivity? Yes / No

Do you have a Latex allergy? Yes / No

Do you have an Immune System condition? Yes / No

I have read, or had explained to me, the information sheet relating to the Boostrix Tdap vaccine (Tetanus shot). I have been given the chance to ask questions and have been provided answers by this medical practice. I understand the benefits and risks of the vaccination as described in the information sheet provided.

I request the Tdap vaccine be given to me (or to the person for whom I am authorized to make this request).

I authorize the release of any medical or other information necessary to process a Medicare or insurance claim.

_________________________________ _____________________
Signature(or Parent/Guardian) Date

For office use only:

Injection Site: Left arm______ Right arm______

Manufacturer____

Lot No:_________________________ Expiration:_____________

Medical Staff initials:______________________ Date:_________