Student Tdap Registration Form

Required information in the **Bold boxes** *must be filled in. Please Print.*

Student's Basic information

Last Name of Student	First Name of Student	Middle Initial	Sex: ❑ Male ❑ Female
Last Name of Legal Guardian	First Name of Legal Guardian		

Student's Date of Birth Month ____ Day ____ Year ____ **Student's Age** ____

Street Address			Apartment number
City		State	Zip Code
Home Phone Number	Cell Phone Number		

Does the student consider himself or herself Hispanic or Latino? ❑ Yes ❑ No

Which category best describes the race of the student? (please select **ALL** that apply)
❑ White ❑ Black or African American ❑ Asian ❑ Native Hawaiian or Pacific Islander
❑ American Indian or Alaska Native ❑ Other

Insurance Information:
❑ CareSource ❑ Molina ❑ Medicaid ❑ Other ____________________
Information from insurance card: Policy number ____________________ Phone number_________________
Claims address on insurance card____
❑ The student does not have health insurance.
I am unable to pay for services rendered. (initial for hardship waiver)_____ Family size____ Income________

Screening

	Yes	No	Don't Know
Has the student had any serious reaction to a vaccine in the past?	❑	❑	❑
Has the student had an allergic reaction to a vaccine in the past?	❑	❑	❑
Has the student had a seizure, brain, or nerve problem?	❑	❑	❑
Is the student pregnant?	❑	❑	❑

Date of last tetanus shot (DTaP, Td, or Tdap)? ____ / _____ / _________
The Tdap booster is not needed now if the student has proof of a tetanus shot within the last 5 years

Consent by Guardian

I have read or had explained to me the *Tdap (whooping cough) Vaccine Information Statement* and I understand the risks and benefits. I give consent for my child named at the top of this form to get vaccinated. I give permission for Columbus Public Health staff to diagnose, treat and care for the needs of the above mentioned client. I also understand that any care received outside Columbus Public Health (e.g., referred care) will not be paid for by Columbus Public Health.

I understand that the Privacy Notice of Columbus Public Health is available on the internet at: publichealth.columbus.gov/Asset/iu_files/HIPAA_Privacy_Notice.pdf . I can also have it mailed to me by calling 614-645-2738.

Parent or Guardian Signature:________________________________ Date:_______________

Do not write in the gray area—Health Department use only

Office Assessment (99211/15) *NG encounter#*_________
Staff Screener Signature________________________ Boostrix 11-18 IM (90715/10) *TC*____ *TP*____
Manufacturer______GSK__________ ☐ Left Deltoid ☐ Right Deltoid
Lot Number_____AC52B045BA_____
Expiration Date___10/27/2011_____ Nurse Signature ________________________________Date________

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