2018/19 Tdap (Tetanus, Diphtheria, Pertussis) VACCINE CONSENT FORM

Information about person to be vaccinated ***(Please print)***

Last Name:_____

First Name: _____ Age: _____

Date of Birth: _____ Sex: _____ M _____ F

Address: _____

City: _____ Zip: _____

Parent/Guardian: _____

Phone number: _____

(For office use only):

Hamlin County OCFS #128

300 4th Street
Hayti SD 57241

phone: (605)783-3681

★ State Law requires 1 dose for Middle School entry

The South Dakota Immunization Information System (SDIIS) is an automated system to document vaccinations given in South Dakota. SDIIS will give parents access to their child's immunization record from any participating South Dakota provider. SDIIS also allows providers to send reminder notices regarding needed immunizations. Health care providers, health care facilities, federal or state agencies, welfare agencies, school or family day care facilities may have access to this information. Immunization records remain confidential, and any person who fails to protect the confidentiality of this information is guilty of a Class 1 misdemeanor. If you choose **NOT** to have your/your child's immunization record shared with other providers you may request a refusal form.

INSURANCE COVERAGE

_____ Enrolled in Medicaid **MUST ATTACH COPY OF CARD**
_____ No health insurance
_____ Insurance **MUST ATTACH COPY OF CARD**

_____ American Indian or Alaskan Native
_____ Health insurance DOES NOT pay for vaccines*
***MUST ATTACH COPY OF CARD**

For Dependent: Name of policy holder _____ **Date of Birth** _____ **Relationship** _____

Please answer the following questions for the person to be vaccinated:

	YES	NO	Don't Know
1) Is the child sick today?	_____	_____	_____
2) Does the child have allergies to medications, food, a vaccine component, or latex?	_____	_____	_____
3) Has the child ever had a serious reaction to a vaccine in the past?	_____	_____	_____
4) Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	_____	_____	_____

I have been provided a copy of and have read or have had explained to me the information about tetanus, diphtheria, and pertussis. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

If covered by private insurance, I authorize SDDOH to release medical information necessary to determine benefits payable for this service. I understand I am financially responsible regardless of insurance coverage.

Signature _____ **Date** _____

(Parent or guardian if minor)

For child being vaccinated at a school based clinic

If you are completing this form for a child to be vaccinated at school and you will not be accompanying him/her, please provide a phone number where you can be reached on the day of the clinic. **PHONE:** _____

for office use only

	Date/Time	Vaccine Manufacturer	Vaccine Lot number	Route	Site **(Circle)**	Date of VIS Publication	Full signature of person administering vaccine
Tdap Vaccine				IM *	Left Deltoid Right Deltoid	2/24/15	

KEY: * IM-intramuscularly

Version 01/23/2019

The Department of Health Notice of Privacy Practices can be found on the following website: http://doh.sd.gov/documents/HIPAANotice.pdf