

## 2011--2012 Tdap VACCINATION RECORD

**Information about person to receive vaccine (please print)**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Phone number \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

**For a child being vaccinated - check any that apply**

(Check here if none apply) \_\_\_\_\_

Enrolled in Medica Please provide Medicaid # \_\_\_\_\_  
 Does not have health insurance \_\_\_\_\_  
 American Indian or Alaskan Native \_\_\_\_\_  
 Health insurance that DOES NOT pay for vaccine \_\_\_\_\_

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.

REFUSAL TO RELEASE INFORMATION: I have read or had explained to me the South Dakota Immunization Information System (SDIIS). I understand the benefits of allowing my child's immunization record to be shared with other primary care providers and public health officials. However, if I choose **NOT** to have my child's immunization record shared with other providers I will request a refusal form.

**Please answer the following health screening questions**

	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 problem? _____	_____	_____	_____

**Children who have received a prior dose of Tdap do not need to be re-vaccinated at this time.**

**CONSENT for Vaccination**

I have been provided a copy of and have read or have had explained to me the information about Tetanus, Diphtheria, Pertussis diseases and the Tdap vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and the risks of the vaccine and ask that the vaccine be given to the child above for whom I am authorized to make this request.

**Signature** (Parent or guardian if a minor) \_\_\_\_\_ **Date** \_\_\_\_\_

If you are completing this for your child and do not plan to attend the clinic, please provide a phone number where you could be reached on the day/time of the clinic \_\_\_\_\_

If you would like to review the Department of Health Notice of Privacy Practices refer to website: <http://doh.sd.gov/PDF/HIPAANotice.pdf>

**for office use only**

**Tdap**

Date/Time	Vaccine Manufacturer	Vaccine Lot number	Route	Site Circle	Date of VIS Publication	Signature of person administering vaccine
			IM	Right Deltoid	Nov. 18 2008	
				Left Deltoid		

IM - Intramuscularly