

ADACEL/Tdap VACCINE ADULT ADMINISTRATION SHEET

(one sheet per adult)

As a convenience to our families and in response to the public health need to increase vaccine rates for adults living with infants we are pleased to offer in office immunization with Tdap vaccine which protects against whooping cough, tetanus and diphtheria.

Name of infant seen at Willows: _____

Date of Birth: _____

I _____

Relation to infant: _____

Waive any Medical or Legal responsibility to Willows Pediatric Group in connection to the receipt and administration of the combination vaccine for whooping cough, tetanus and diphtheria, known as Tdap, trade name Adacel manufactured by Sanofi Pasteur. I agree to not hold Willows Pediatric Group responsible for any adverse reaction or problems that might arise from receiving this vaccine in our office or any complications that might arise in the future from this vaccine.

In order to meet the health requirements for this vaccine, I agree that:

1. I am less than 65 years of age
2. I do not have a history of severe allergic reaction or serious side effect after a previous dose of similar vaccine or components of this vaccine
3. I am presently healthy with no acute illness with or fever
4. I do not have an unstable neurological condition
5. I am not on medications that would contraindicate the safe administration of this vaccine (such as prednisone or immunosuppressive medications)
6. I have not received a tetanus containing vaccine within the last 2 years

We also recommend that you check with your Physician to make sure that there are no additional contraindications that would not allow you to have the Tdap vaccine administered .

Adult's Signature: _____

Printed Name: _____

Payment of \$69.00 received: _____ cash/check/charge by _____

Vaccine = Adacel CPT Code = 90715

Sanofi Pasteur: Lot # _____ Expiration: _____

Date of Administration: _____ By: _____

