Crafton Hills College, Health and Wellness Center

TDAP QUESTIONNAIRE AND CONSENT

1.	Have you had a DPT series (of 3 shots) as a child?	Yes_____	No_____
2.	When was your most recent DPT, DT, Td or tetanus toxoid?	Year_____	
3.	Have you ever had a Tdap before?	Yes_____	No_____
4.	Have you ever had a severe reaction to a DPT, DT, Td or tetanus toxoid?	Yes_____	No_____
5.	Have you ever had a convulsion or problem with your nervous system?	Yes_____	No_____
6.	Are you taking a drug or undergoing a treatment that lowers the body's resistance to infection, such as: cortisone, prednisone, certain anti-cancer drugs, or irradiation?	Yes_____	No_____
7.	Are you allergic to Thimersol mercurial antiseptic?	Yes_____	No_____
8.	Do you have a SEVERE allergy to latex?	Yes_____	No_____
9.	Do you have an illness with fever today or had same during the past week?	Yes_____	No_____
10.	Are you sick right now with anything more than a cold?	Yes_____	No_____
11.	Are you or could you be pregnant? (Doctors usually do not recommend giving any vaccines to pregnant women unless there is a specific need. Pregnant women who need tetanus vaccine should consult their physician).	Yes_____	No_____

Please rate the degree to which you agree or disagree with the following statements:

	Strongly Agree	Agree	Disagree	Strongly Disagree
The services provided by the Health & Wellness Center were beneficial to me.				
Being able to access the services provided by the Health & Wellness Center ON Campus provides me with the opportunity to devote more time to my class work.				
It would be a financial hardship for me to obtain the services provided by the Health & Wellness Center OFF Campus.				
If the services provided by the Health & Wellness Center were not available at CHC, I would be able to access the services somewhere else.				

VACCINE TO BE GIVEN: TETANUS AND DIPTHERIA PERTUSSIS (Tdap)

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (Please Print)

Last Name First Name MI Birthdate Age

Address City

County State Zip

Additionally, signing this form is verification that you have received the vaccine information sheet (VIS), the notice of privacy practice for CHC, Health and Wellness Center, as required by HIPAA Federal Regulations and the CAIR notice .

Signature of person to receive vaccine or person authorized to make the request Date

FOR CLINIC USE

Clinic Identification

Date Vaccinated

Manufacturer

Lot Number

Site of Injection

Signature of Vaccineor Adminstrator

5/24/2007