

First Name:		Last Name:	
Birthdate:	Age:	Weight:	Sex assigned at birth: ☐ Male ☐ Female
Address:		City:	State: Zip:
Phone:		Last 4 digits of Social Security Number:	
Primary Care Physician (PCP) First Name:		PCP Last Name:	
PCP Address:			
PCP Phone:		PCP Fax:	
Insurance:	Group:	ID #:	

Please check "yes" or "no" for each question		Yes	No	Notes
1a.	Have you previously received a dose of a tetanus-containing vaccine?			
1b.	If so, please indicate when you received it:			
2.	Have you had a seizure, a brain disorder, Guillain-Barré Syndrome (GBS), or other nervous system problem? Has a parent or sibling had a seizure?			
3.	Have you had a stem cell transplant?			
4.	Are you at risk for disease due to travel, your occupation, your activities, an outbreak, or contact with an infected person or animal?			
5.	Are you sick today?			
6.	Do you have allergies to medications, food (Ex: bovine milk protein), a vaccine component (Ex: polysorbate, formaldehyde), or latex?			
7.	Have you ever had a serious reaction after receiving a vaccine?			
8.	Have you ever felt dizzy or faint before, during, or after a shot?			
9.	Are you anxious about getting a shot today?			
10.	Are you pregnant or nursing? What week of pregnancy are you? _____			

Consent for services, medical records, and HIPAA privacy information

Medicare/Medigap Policy Holders: I request and assign payment of authorized Medicare and/or Medigap benefits, as applicable, to be made on my behalf to Giant Eagle Pharmacy for any products or services furnished by them to me. I authorize the release of medical information about me to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents as necessary to determine benefits payable for these or related services.

All Patients: I acknowledge receipt of Giant Eagle's Notice of Privacy Practices and authorize the release of immunization information to Federal and state authorities and to any covering health insurance provider(s). For the vaccine(s) indicated hereon, I acknowledge receipt of the relevant Vaccine Information Sheet (VIS) or EUA Fact Sheet. I affirm that I have had the opportunity to ask questions and that I voluntarily assume full responsibility for any reactions that may result. I request administration of the immunization(s) to me or to the patient identified hereon for whom I am the legal guardian. I, for myself, my wards, heirs, executors, personal representatives and assigns, hereby release Giant Eagle, Inc., the hosting facility and its managing and operating companies and owners, the event sponsors, and each entity's respective affiliates, subsidiaries, divisions, directors, contractors, agents and employees, from any and all claims arising out of, in connection with, or in any way related to, the receipt or administration of the immunization(s) indicated hereon. Further, I affirm that I request and access these services at my own risk and will not hold the aforementioned parties, to any extent whatsoever, liable, responsible, or in any way accountable for any loss, physical or personal injury, death, or damages suffered or sustained at any time in connection with or as a result of their offering of this vaccine program, the administration or receipt of the vaccines requested, or access to or use of the hosting facilities.

Signature (Patient or Parent/Legal Guardian): _____ Date: _____

Print Full Legal Name (Patient or Parent/Legal Guardian): _____

Healthcare Provider Only: By signing below, I agree that as the immunizing healthcare professional: I reviewed the patient's information and screening question responses. This vaccine is appropriate for this patient based on the responses to the screening questions and age guidelines according to ACIP recommendations, Giant Eagle's current vaccine protocols, and state regulations. Appropriate written education has been provided to the patient, including a Well Child Visit Reminder as applicable.

Signature (Immunizer): _____ Date: _____

Print Name (Immunizer): _____ Title (Immunizer): _____

If Pharmacy Intern or Technician, overseeing Pharmacist to sign and print name: _____

If using Immunization Protocol, Ordering Physician Name: _____

☒	Age (yrs)	Tetanus Vaccine (Mfrgr)	Dose	NDC
	7+	Adacel (Sanofi)	0.5 mL	49281-0400-20
	7+	Boostrix (GSK)	0.5 mL	58160-0842-52
	7+	Tenivac (Sanofi)	0.5 mL	49281-0215-58
Sig: Administer 1 shot intramuscularly into the: ☐ Left Deltoid ☐ Right Deltoid				

Additional
VIS Date: Tdap 1/31/25 or Td 8/6/21
Lot Number:
Expiration Date:
Clinic:
No Refills

Tdap (Tetanus, Diphtheria, Pertussis) Vaccine: *What You Need to Know*

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Tdap vaccine can prevent **tetanus, diphtheria, and pertussis**.

Diphtheria and pertussis spread from person to person. Tetanus enters the body through cuts or wounds.

- **TETANUS (T)** causes painful stiffening of the muscles. Tetanus can lead to serious health problems, including being unable to open the mouth, having trouble swallowing and breathing, or death.
- **DIPHTHERIA (D)** can lead to difficulty breathing, heart failure, paralysis, or death.
- **PERTUSSIS (aP)**, also known as “whooping cough,” can cause uncontrollable, violent coughing that makes it hard to breathe, eat, or drink. Pertussis can be extremely serious especially in babies and young children, causing pneumonia, convulsions, brain damage, or death. In teens and adults, it can cause weight loss, loss of bladder control, passing out, and rib fractures from severe coughing.

2. Tdap vaccine

Tdap is only for children 7 years and older, adolescents, and adults.

Adolescents should receive a single dose of Tdap, preferably at age 11 or 12 years.

Pregnant women should get a dose of Tdap during every pregnancy, preferably during the early part of the third trimester, to help protect the newborn from pertussis. Infants are most at risk for severe, life-threatening complications from pertussis.

Adults who have never received Tdap should get a dose of Tdap.

Also, **adults should receive a booster dose of either Tdap or Td** (a different vaccine that protects against tetanus and diphtheria but not pertussis) **every 10 years**, or after 5 years in the case of a severe or dirty wound or burn.

Tdap may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of any vaccine that protects against tetanus, diphtheria, or pertussis**, or has any **severe, life-threatening allergies**
- Has had a **coma, decreased level of consciousness, or prolonged seizures within 7 days after a previous dose of any pertussis vaccine (DTP, DTaP, or Tdap)**
- Has **seizures or another nervous system problem**
- Has ever had **Guillain-Barré Syndrome** (also called “GBS”)
- Has had **severe pain or swelling after a previous dose of any vaccine that protects against tetanus or diphtheria**

In some cases, your health care provider may decide to postpone Tdap vaccination until a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting Tdap vaccine.

Your health care provider can give you more information.



**U.S. CENTERS FOR DISEASE
CONTROL AND PREVENTION**

4. Risks of a vaccine reaction

- Pain, redness, or swelling where the shot was given, mild fever, headache, feeling tired, and nausea, vomiting, diarrhea, or stomachache sometimes happen after Tdap vaccination.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at www.vaers.hhs.gov or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at www.hrsa.gov/vaccinecompensation or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at www.fda.gov/vaccines-blood-biologics/vaccines.
- Contact the Centers for Disease Control and Prevention (CDC):
 - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
 - Visit CDC's website at www.cdc.gov/vaccines.

