Site:
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R

CHET JOHNSON DRUG
Amery, Wisconsin

B

Tdap (Tetanus, Diptheria and acellular Pertussis) Vaccination

Please fill out the requested information completely:

1) Name: _____ Birthdate: _____

2) Weight:

MALE:	FEMALE:
☐ Less than 130lbs	☐ Less than 130lbs
☐ Between 130lbs and 260lbs	☐ Between 130lbs and 200lbs
☐ More than 260lbs	☐ More than 200lbs

3) Allergies:

- ☐ No allergies
- ☐ Latex
- ☐ DTap, Tdap, or Td vaccine (including encephalopathy after pertussis-containing vaccines)
- ☐ Other vaccines or vaccine components: _____
- ☐ Other allergies: _____

4) Have you received any other vaccinations in the last month:

☐ No ☐ Yes (List vaccine and date): _____

5) Have you received vaccinations for tetanus, diphtheria and/or pertussis in the last 10 years?

☐ No ☐ Yes (List vaccine and date): _____ ☐ Unknown

6) Have you ever had Guillain-Barre Syndrome?

☐ No ☐ Yes (If yes, when?): _____

7) Do you have an unstable or progressive neurological problem, such as uncontrolled seizures?

☐ No ☐ Yes (please explain):_____

8) We will add a record of this vaccination to the Wisconsin Immunization Registry (WIR) to keep your records with your other health care providers up-to-date. You may decline to be added to WIR; it will then be your responsibility to notify your health care providers as needed.

☐ Do NOT submit a record of this vaccination to the Wisconsin Immunization Registry

9) Please sign and date:

Signature: _____ Date: _____

If you would like us to bill Medicare or insurance for this vaccination, please provide your insurance card(s) with this form.