Pediatric Junction, PA
Keeping children's health on the right track!
office of Dr. Anna Lincoln

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ADULT NON-PATIENT
Tdap VACCINE SCREENING QUESTIONNAIRE

DATE:_____

NAME:_____ **DOB:**_____

***Payment for the vaccine is due at the time of service. Price: $65*

Please circle YES or NO to following questions:

1.	**Have you had a severe allergic reaction to a vaccine component (T, D or P) or prior dose of DTaP, DTP, DT or Td?**	YES	NO
2.	**Have you had encephalopathy within 7 days of administration of a pertussis vaccine that is not attributable to another identifiable cause?**	YES	NO
3.	**Do you have a history of severe local reaction following a previous dose of tetanus or diphtheria-toxoid-containing vaccine?**	YES	NO
4.	**Do you have a progressive neurological disorder, uncontrolled epilepsy or progressive encephalopathy?**	YES	NO
5.	**Do you have a history of Guillain-Barre syndrome (A condition in which the immune system attacks the nerves. Paralysis may occur.) within 6 weeks after a previous dose of tetanus toxoid-containing vaccine?**	YES	NO
6.	**Are you currently ill with a moderate or severe acute illness?**	YES	NO
7.	**To the best of my knowledge, I have received a complete series of 3 doses of DTaP, DTP, DT or Td. (HINT: If you had your childhood vaccines in the US the answer is YES)**	NO	YES
8.	**Do you have a *Severe Latex Allergy?***	YES	NO

I hereby acknowledge the above is true and I have reviewed the vaccine information sheet. I understand that if I have had a tetanus-containing vaccine within the past 2 years I may be at risk for a more severe vaccine reaction.

I am choosing to pay out-of-pocket for my vaccine and agree to not use my insurance benefits. No insurance will be filed by Pediatric Junction.

_____
Signature and Date

FOR INTERNAL USE ONLY:

If any of the above questions in the left hand column are answered, consult with provider. If all of the answers in the right hand column are circled, this patient is authorized to receive the appropriate dose of Tdap vaccine.

DOSE GIVEN:

0.5mL IM TDAP Preservative Free

R L DELTOID (Manufacturer: Sanofi Pasteur)
Lot#

Exp:

_____
Staff Signature and Date

Approved By: _____

TOTAL: $_____

PAID BY:_____

□ Cash □ Credit/Debit □ Check

COLLECTED BY:_____

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