HOWARD COUNTY GENERAL HOSPITAL

JOHNS HOPKINS MEDICINE

OCCUPATIONAL HEALTH

TETANUS, DIPHTHERIA, AND PERTUSSIS (TDap) VACCINE CONSENT

You are being given the Tetanus, Diphtheria, and Pertussis (TDap) vaccine to protect you against these diseases. The most common side effects from this vaccine are soreness, redness or swelling at the site of injection. The Centers for Disease Control (CDC) recommends using acetaminophen or ibuprofen (non-aspirin) to reduce the soreness. Please return or contact Occupational Health at ext. 7838 immediately if you experience any problems.

You should not receive the vaccine if:

- You have ever had an allergic reaction, seizures, coma, or other problems with the Td, or other tetanus/diphtheria vaccines (DTP, DtaP, DT).
- You are moderately or severely ill
- You have a history of Guillian Barre' Syndrome
- You have concerns because you are currently pregnant – please see your OB/GYN and provide written documentation that you can receive the TDap vaccination

Acceptance of the Vaccination

I have read the information about the Tetanus, Diphtheria, and Pertussis vaccine. I understand the benefits and risk of the vaccine. I have had ample opportunity to ask questions and have them answered to my satisfaction regarding the disease, vaccine, and the possible risks and benefits. I further understand that Howard County General Hospital and it's' employees make no guarantee as to the effectiveness of the vaccine or the likelihood or severity of the occurrence of any of the risks from the vaccine.

I request that vaccine be given to me, and I have been given the Vaccine Information Statement dated_____.

_____ _____ _____

Employee's Name - **PRINTED** Employee's Signature Date

Date of Dose: _____

Lot #:_____ Exp. Date: _____

Site: (circle one) left upper arm right upper arm

Administered/Witnessed by: _____

Declination of the Vaccine:

I decline the vaccine. Reason - please check:

____ previously had the TDap Vaccine and will supply proof of vaccination
____ Other: please explain: _____

I understand that the TDap vaccination or proof of receipt is required for employment. If I am declining for a medical or religious reason, I will have the appropriate form completed by the appropriate person and provide Occupational Health with copies of such, prior to my start date. Failure to provide this information may delay my start date.

_____ _____ Phone #:_____

Employee Signature Date

_____ _____

Witnessed by – Occupational Health Nurse Signature Date