

Authorization To Receive Tetanus, diphtheria, acellular pertussis (Tdap) Vaccine

Information collected on this form will be used to document authorization for receipt of Tdap vaccine at your child's school. Information may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with your child to assure completion of the vaccine schedule.

My signature below authorizes my child to receive Tdap (Tetanus, diphtheria, acellular pertussis) vaccine
[Required (1 dose)]

Patient's Name (Last, First, Middle Initial)	Mother's Maiden Name (Last, First, Middle Initial)
--	--

Address	P. O. Box	City	County	State	Zip Code
---------	-----------	------	--------	-------	----------

Home Telephone Number ()	Date of Birth (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
----------------------------------	----------------------------	---

Race (Check one) <input type="checkbox"/> African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Pacific <input type="checkbox"/> White <input type="checkbox"/> Other	Ethnicity (Check one) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino
---	---

Eligibility Status - This section must be completed. (Check all that apply)

<input type="checkbox"/> Native American	<input type="checkbox"/> Badger Care	<input type="checkbox"/> Insured, Vaccines Covered
<input type="checkbox"/> Medicaid Eligible	<input type="checkbox"/> No Health Insurance	<input type="checkbox"/> Insured, Vaccines Not Covered

Name of Physician	Name of School	Grade
-------------------	----------------	-------

Name of Parent or Guardian Responsible for Patient (Last, First, Middle Initial)	Relationship to Patient
--	-------------------------

Okay to share immunization data with Wisconsin Immunization Registry (WIR)?
 Yes No

I have been given a copy and have read, or have had explained to me, information about the disease(s) and vaccine(s) to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request.

Wisconsin Medicaid restricts billing recipients for any covered service(s). I understand that if I am a Medicaid / BadgerCare recipient I cannot be charged an administration fee or asked for any type of donation for the administration of any vaccine that is being provided.

SIGNATURE - Person to receive vaccine or person authorized to sign on the patient's behalf. X	Date Signed
--	-------------

FOR OFFICE USE

Tdap: route= IM site (circle one) RD or LD dose number= 1

Manufacturer _____ Lot No. _____ VIS date: 11/18/08

Signature and title of person administering vaccine: _____ Date vaccine administered: _____

LHD clinic address: _____