Health & Home CARE Society of BC

Tetanus/Diphtheria (Td absorbed) Adolescent/Adult Booster Consent Form

Name (please print): _____
SURNAME GIVEN NAME

Date of Birth _____ Phone _____
Address _____

Health Assessment	Yes	No
Have you had a tetanus diphtheria booster within the past 10 yrs? Adverse reactions are associated with too frequent boosters.		
Is there a possibility that you are pregnant? This vaccination can be delayed until after delivery but pregnancy is not a contraindication.		
Have you had an allergic reaction to this vaccine or any vaccine?		
Have you had Guillain-Barré syndrome within 8 weeks of a tetanus immunization? If yes, no vaccination will be given today.		
Are you allergic to formaldehyde (a preservative found in shampoos, creams, dentifrices and root canal paste), aluminum phosphate?		

I understand that:

- I will receive the booster injection in a muscle in the arm and that following the immunization local bruising and swelling may occur. Severe local reactions usually occur as a result of too frequent immunization. Some site redness, warmth, itchiness, swelling or soreness may persist for 1-2 days but prolonged reaction needs to be reported to my doctor.
- Very rarely, immediate allergic reactions such as hives, swelling of the tongue and lips or difficulty breathing can occur. This is a serious medical emergency and should be treated immediately.
- I must stay at the clinic to be observed by the nurse for 15 minutes after I receive the booster.

Acknowledgment and Waiver: I have read the information about Tetanus/Diphtheria Booster and have had a chance to ask questions which were answered to my satisfaction. I fully understand the benefits and risks of the vaccine. I waive any claim for damages that I or anyone claiming on my behalf may have against my employer and the Health & Home Care Society of BC and their directors, officers, employees and agents on account of injury or misfortune I may suffer as a result of this immunization.

I request that Tetanus/Diphtheria Booster vaccine be administered.

Signature _____ Date _____

Td Absorbed	Sanofi Pasteur	Lot #	Expiry Date:	Dosage:
Injection Site(circle site used)		Deltoid: Right or Left		Reaction
Signature of Nurse:			Date/Time:	