MHI Health
Mile Hi Immunizations & Healthcare Services

MILE HI IMMUNIZATIONS, LLC
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2016 TETANUS/DIPHTHERIA/ PERTUSSIS CONSENT FORM

This vaccine is recommended for individuals 11 – 64 years of age every 10 years.

NAME LAST (one character per box) NAME FIRST MIDDLE INITIAL

STREET ADDRESS

CITY STATE ZIP

SEX DATE OF BIRTH AGE PHONE

M / F M M / D D / Y Y Y Y

Precautions & Contraindications: Please Shade-In "Yes" or "No" for each question.

Have you ever had a Tetanus/Diphtheria shot before? ..... YES ___ NO ___
If you have received a Tetanus/Diphtheria shot, was it less than 10 years ago? ..... YES ___ NO ___
Are you pregnant or lactating (company policy does not allow us to vaccinate pregnant or lactating women)? ..... YES ___ NO ___
Have you ever had an adverse reaction to another vaccine? ..... YES ___ NO ___
Please list the adverse reaction _____
Do you have a past history of Guillain-Barre syndrome? ..... YES ___ NO ___
Do you have any hypersensitivity to any component of the vaccine, including thimerosal? ..... YES ___ NO ___
Do you have a history of sensitivity to latex? (refers to gloves and rubber stopper) ..... YES ___ NO ___
Do you currently have a fever or respiratory illness or any other type of infection? **Adverse reactions may include redness, warmth, swelling, tenderness, rash, systemic-malaise, slight fever, pain, low blood pressure, nausea, hives, swelling of the mouth, difficulty breathing, shock and very rarely, anaphylactic reactions resulting in death.** YES ___ NO ___

NOTE: If you are between the ages of 11-18 and have not had a tetanus vaccine in the past 5 years you may receive a TDaP vaccine. If you are between the ages of 19 – 64 and have not had a tetanus vaccine in the past 2 years, you may receive a TDaP vaccine.

BASED UPON YOUR RESPONSES TO THE ABOVE QUESTIONS, THE NURSE MAY REFER YOU TO YOUR PHYSICIAN FOR YOUR INJECT ION

I have read the adverse reactions listed above associated with the Tetanus vaccine and I am aware that a copy of the vaccine manufacturer's drug information sheet is available at the CDC website. Furthermore, I have also had an opportunity to ask questions about this immunization. I believe that the benefits outweigh the risks and I assume full responsibility for any reactions that may result. My medical record may be shared with my physician/insurance. I waive and release any and all claims I, or anyone claiming by or through me, now have or may hereafter acquire against Mile High Health Solutions, the clinic site sponsor and their respective parent, subsidiaries, and each of their directors, officers, employees, and agents for any and all damages or injuries arising out of or related to the receipt of the Tetanus/Diphtheria shot, including, without limitation, if I, the person named below for whom I am authorized to make this request, contract Tetanus, other related diseases, or suffer any other damages or adverse reactions, including death, following administration of this Tetanus shot. I am requesting that the immunization be given to me or the person named below for whom I am the legal guardian.

X_____(Signature/Legal Guardian) Date: _____

For OBSERVATION: Please remain on the premises for 10 minutes following vaccination. If you leave the area, you are doing so against medical advice. Your safety is our primary concern.

THIS SECTION TO BE COMPLETED BY NURSE

(Please note, if one of the following is NOT a clear choice, shot must be paid for at time of service):

Customer_____ **Employee**_____ **Insurance**_____ **Medicare**_____

Bill Company_____ Cash_____ Check_____ Credit card_____

SITE: ☐ LD / ☐ RD NURSE'S INITIALS: _____

LOT #: CLINIC DATE: / / 2016