# HEALTHLINE
## MEDICAL GROUP

Please Answer Questionnaire:

1. Are you allergic to Tetanus, Diptheria or Pertussis? YES___ NO___
2. When was your last Tetanus or

   Tetanus, Diptheria and Acellular Pertussis (Tdap)? DATE_____
3. Do you have the tendency to faint? YES___ NO___
4. Are you pregnant? YES___ NO___

Please Print:

PATIENT NAME _____

DATE OF BIRTH_____ SS# _____

I have been informed about the Tetanus/ Tdap Vaccination. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risk of the Tetanus/ Tdap vaccine and request that it is given to me or the person named below for whom I am authorized to make the request.

_____ DATE_____
Signature

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Please check off which vaccine was given:

Tetanus _____ Tdap_____

VACCINATION ADMINISTERED ON:_____

SITE: R___ L___ DELTOID DOSAGE:_____

EXPIRES:_____ LOT #:_____

MFG:_____

NURSE SIGNATURE:_____

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