

# DEPARTMENT OF PUBLIC HEALTH & ENVIRONMENT

1555 N. 17th Avenue

Greeley, CO 80631

WEBSITE: [www.co.weld.co.us](http://www.co.weld.co.us)

NURSING: (970) 304-6420

FAX: (970) 304-6416

**Tdap Vaccine Questionnaire and Consent**

The following questions will help us determine if you may receive the Tdap vaccine.

|  |  |  |
| --- | --- | --- |
| **Question** | **Yes** | **No** |
| **Is the person receiving shots today an American Native or Alaskan Native?** |  |  |
| **Does the person have:**  | **Medicaid?** |  |  |
|  | **Colorado Child Health Plan Insurance?** |  |  |
|  | **Other health insurance?** |  |  |
| **If the person receiving shots does have insurance does it cover immunizations?** |  |  |
|  |  |  |
| 1. **If the person receiving shots is under 18 years, is his/her parent or guardian present?**
 |  |  |
| 1. **Is the person receiving shots sick today?**
 |  |  |
| 1. **Does the person receiving shots have allergies to medications, food, or any vaccine?**
 |  |  |
| 1. **Has the person receiving shots ever had a serious reaction after receiving a vaccine?**
 |  |  |
| 1. **Has the person receiving shots had a seizure, brain, Guillain Barré Syndrome or other nervous system problem?**
 |  |  |
| 1. **For women: Is the person receiving shots pregnant?**
 |  |  |

**VIS Date \_\_\_\_\_\_\_ Date Given \_\_\_\_\_ Manufacturer \_\_\_\_\_ Lot #\_\_\_\_\_\_\_\_\_ EXP\_\_\_\_\_\_ Site\_\_\_\_ Given by:\_\_\_\_\_\_\_\_\_\_**

I have read the information contained in the Tdap Vaccine Information Statement. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that the vaccine indicated be given to me or to the person named below for whom I am authorized to make this request. I have had the opportunity to review or receive the notice of privacy policy (HIPAA). I understand this record will be kept on file at the Weld County Health Department.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Client Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Male\_\_\_\_ Female\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Cuestionario para Tdap**

Las siguientes preguntas nos ayudan a determinar si puede recibir la vacuna Tdap.

|  |  |  |
| --- | --- | --- |
| **Pregunta** | **Sí** | **No** |
| **¿ Es la persona que va recibir vacunas es Indígena Norteamericano o de Alaska?** |  |  |
| **¿Cuenta usted con:** | **Medicaid?** |  |  |
|  | **Colorado Child Health Plan Insurance?** |  |  |
|  | **Otro tipo de Seguro Médico?** |  |  |
| **Si usted cuenta con Segura Médico, ¿paga los gastos de vacunas?** |  |  |
|  |  |  |
| 1. **¿Si la persona que recibe vacunas es menor de 18 años, están presentes los padres o persona responsable?**
 |  |  |
| 1. **¿Está enferma la persona que va a recibir las vacunas hoy?**
 |  |  |
| 1. **¿Es alérgica a alguna comida o medicina la persona que va a recibir vacunas?**
 |  |  |
| 1. **¿Ha tenido la persona que va a recibir las vacunas alguna reacción con sus vacunas?**
 |  |  |
| 1. **¿Tiene la persona que va a recibir vacunas algún desorden que afecta su cerebro o sistema neurológico, por ejemplo alguna condición que causa ataques?**
 |  |  |
| 1. **Para mujeres: ¿Está embarazada la persona que va a recibir las vacunas?**
 |  |  |

**VIS Date \_\_\_\_\_\_\_ Date Given \_\_\_\_\_ Manufacturer \_\_\_\_\_ Lot #\_\_\_\_\_\_\_\_\_ EXP\_\_\_\_\_\_ Site\_\_\_\_ Given by:\_\_\_\_\_\_\_\_\_\_**

He leído la información contenida en la hoja de Información Importante acerca de la vacuna Tdap. He tenido la oportunidad de hacer preguntas, las cuales fueron contestadas a mi satisfacción. Yo creo que entiendo los beneficios y riesgos de la vacuna y autorizo a que la vacuna indicada me sea aplicada ó a la persona nombrada abajo por quien yo estoy autorizado(a) a hacer este requerimiento. Yo he tenido la oportunidad de revisar o recibir la noticia de la póliza de privacidad (HIPAA). Yo entiendo que este historial médico será mantenido en el Departamento de Salud de Weld County.

Firma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha: \_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Nombre con letra de molde: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha de nacimiento: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_Masculino\_\_\_\_Feminino\_\_\_

Dirección: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Teléfono (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

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Nombre con letra de molde: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fecha de nacimiento: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ Masculino\_\_\_ Femenino\_\_\_

Dirección: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Teléfono (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_