CHET JOHNSON DRUG
Amery, Wisconsin

B

Tdap (Tetanus, Diptheria and acellular Pertussis) Vaccination (aka Boostrix)

Please fill out the requested information completely:

1) Name: _____ Birthdate: _____
2) Which arm would you like to use? ☐ LEFT ☐ RIGHT
3) Allergies:
   - ☐ No allergies
   - ☐ DTap, Tdap, DTP, or Td vaccine (including encephalopathy after pertussis-containing vaccines)
   - ☐ Other vaccines or vaccine components: _____
   - ☐ Other allergies: _____
4) Are you currently experiencing any acute illness such as a cold, fever, or other infection?
   ☐ No ☐ Yes (please explain):_____
5) Have you received vaccinations for tetanus, diphtheria and/or pertussis in the last 10 years?
   ☐ No ☐ Yes (List vaccine and date): _____ ☐ Unknown
6) Have you ever had Guillain-Barre Syndrome?
   ☐ No ☐ Yes (If yes, when?): _____
7) Do you have an unstable or progressive neurological problem, such as uncontrolled seizures or encephalopathy?
   ☐ No ☐ Yes (please explain):_____
8) We will add a record of this vaccination to the Wisconsin Immunization Registry (WIR) to keep your records with your other health care providers up-to-date. You may decline to be added to WIR; it will then be your responsibility to notify your health care providers as needed. If you do NOT want this vaccination added to the WIR, check this box:
   ☐ Do NOT submit a record of this vaccination to the Wisconsin Immunization Registry
9) Please sign and date:

Signature: _____ Date: _____

Please provide your insurance card(s) with this form if you want the vaccine billed to insurance.