HEALTHY SOLUTIONS, INC.

Tetanus Diphtheria Pertussis (Tdap)
CONSENT FORM

11 Years and Older

Print Name: _____ Sex: ☐ M ☐ F *Check One* Phone: (_____) _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ / _____ / _____ Age: _____ E-mail Address: _____
MM *DD* *YY* (11 years & older)

Who should get the Tdap vaccination?

Everyone (11 years and older) who has not received the Tdap shot within the last 10 years.
Adults should receive a booster dose every 10 years, or earlier in the case of a severe and dirty wound or burn. (Booster dose can be either Tdap or Td)
Tdap is especially important for healthcare professionals and anyone having close contact with a baby younger than 12 months.
Everyone needs protection against these three diseases - diphtheria, tetanus, and pertussis (whooping cough).

PLEASE CHECK YES OR NO FOR EACH QUESTION:	YES	NO
1. Have you received the Tdap vaccine in the past 10 years?	☐	☐
2. Are you ill or not feeling well today?	☐	☐
3. Have you ever had a serious allergic reaction to latex or any component of the vaccine?	☐	☐
4. Have you ever had a serious reaction, severe swelling, severe pain, an arthus reaction, or a neurological disorder including seizures or gone into a coma after receiving a vaccination including DTP, DTaP, DT, Tdap or Td vaccine?	☐	☐
5. Do you have a history of Guillain-Barre' Syndrome or active neurologic disorder? (e.g. MS, epilepsy, etc)	☐	☐
6. FOR WOMEN: Are you pregnant and/or think you might be pregnant?	☐	☐

If you answered "YES" to any of the above questions you can NOT receive the vaccination at this time. Consult your physician.
*If you have any questions, **please ask now before receiving the vaccine.** If you experience any significant delayed reactions, **SEE YOUR PHYSICIAN.***

PRESENT YOUR INSURANCE CARD AT THE CLINIC

☐ Aetna (**No** HCA) ☐ Meritain Health (**No** AdventHealth)
☐ All Savers
☐ Blue Cross (**No** NKC Hospital / **No** OEG, KWF)
☐ Cigna (**No** EPO Connect /SureFIT)

PLEASE CHECK WITH YOUR INSURANCE TO VERIFY COVERAGE

☐ Humana (**No** Humana One, PPOX)
☐ UMR
☐ United Healthcare (**No** Core Plans)

We do NOT accept Tricare, Medicaid, Medicare, Medicare Advantage Plans or ACA Marketplace Plans
(Blue Cross ACA Marketplace is accepted)

Print Name _____
(PARTICIPANT NAME - EXACTLY AS LISTED WITH INSURANCE COMPANY)

Member ID # _____ _____
(REQUIRED FOR ALL INSURANCES LISTED ABOVE) (SUFFIX)

For Healthy Solutions Staff ONLY
☐ Cash
☐ Check #_____
Amount Paid $_____
☐ Employer Paid

I have been offered a copy of the "Vaccine Information Statement" for the vaccine(s) I receive today. I have read the information about the Tetanus Diphtheria Pertussis (Tdap) vaccine and I have had a chance to ask questions. I understand the benefits and risks of the Tetanus Diphtheria Pertussis (Tdap) vaccination and request that the vaccine be given to me or the person named above for whom I am authorized to sign. I agree that Healthy Solutions, Inc. is not responsible or liable if I contract Tetanus Diphtheria Pertussis or other respiratory diseases, or suffer any other adverse reaction or event following administration of the Tetanus Diphtheria Pertussis (Tdap) vaccine. This vaccination is being given to me at my request. As a condition of receiving the vaccine, I, myself, my heirs and executors hereby waive any right I may have to make a claim against Healthy Solutions, Inc. and the sponsoring organization, their affiliates, divisions, subsidiaries, officers, directors, advisory boards, employees, and contractors from any and all claims arising out of, in connection with, or in any way related to my receiving the Tetanus Diphtheria Pertussis (Tdap) vaccine. I authorize Healthy Solutions, Inc. to furnish information to and receive payment from insurance companies for services provided me. I understand that these records may be protected by Federal Regulations and have been offered Healthy Solutions, Inc.'s Notice of Privacy Practices. In order to provide program participation Healthy Solutions, Inc. may provide my name to the sponsoring organization or its designated representative. I agree that Healthy Solutions, Inc., its agents and employees, are not liable if individuals or companies to whom they release information disclose the information without my consent. I accept responsibility for seeking medical attention for any problems associated with receiving the vaccination. **I AGREE TO WAIT IN THE AREA FOR 15 MINUTES AFTER RECEIVING THE VACCINATION(S).**

The acceptance of your health insurance information does not guarantee coverage or payment by your insurance company.
I fully understand that I will be responsible for charges if insurance does not pay.

Participant Signature_____ Date:_____
(or legal Guardian if 11 -17 years old)

Manufacturer	Lot #	Exp. Date	Injection Site	Vaccine	Nurse Signature
❑GSK ❑Sanofi			❑Right Deltoid ❑Left Deltoid	❑Vial ❑Prefilled Syringe	