



Tdap Vaccine Waiver

Part 1: To be completed by the student

Last Name: _____ First Name: _____

ID Number: _____ USF E-mail: _____

Level: BSN MSN MPH MSBH DNP PsyD Non-Degree Seeking

BSN Level: FR1 FR2 SO 1 SO 2 JR 1 JR 2 SR 1 SR2

I have been given the opportunity to be vaccinated with the Tdap vaccine and wish to declare the following as cause for my exemption, by checking "yes" to the applicable statement:

Part 2: To be completed by the Healthcare Provider

Questions	Yes	No
1. Has the student have a life-threatening allergic reaction after a dose of any tetanus, diphtheria, or pertussis containing vaccine?		
2. Does the student have a severe allergy to any component of a vaccine?		
3. Does the student have pervious history of adverse reactions to Tdap of DTP vaccine? <i>Please specify: _____/_____/_____</i>		
4. Is the student receiving immunosuppressive drug therapy?		
5. Has the student has a coma, or long or multiple seizures with 7 days after a dose of DTP or DTaP?		
6. Does the student have epilepsy or another nervous system problem?		
7. Has the student had severe swelling or severe pain after a previous dose of DTP, DTap, DT, Td, or Tdap vaccine?		
8. Has the student had Guillain Barre Syndrome (GBS)?		

IF YOU ANSWERED YES TO ANY OF QUESTIONS 1 THRU 10, PROCEED TO WAIVER OF VACCINE SECTION.

WAIVER OF VACCINATION
<p>WAIVER OF VACCINE – Complete if not eligible to receive vaccine.</p> <p><input type="checkbox"/> I am not eligible to receive the Tdap vaccine based on my medical history (questions 1-8).</p> <p>I am not eligible to receive the Tdap vaccine, and I understand my risk and responsibility. I hereby release, hold harmless, and agree to indemnify the University of San Francisco, its staff, and clinical sites from any and all responsibility or consequences which may result from my lack of inoculation with the Tdap vaccine. I can access a copy, Tdap VACCINE – WHAT YOU NEED TO KNOW, a vaccine information statement developed by the U.S. Department of Health and Human Services (Centers for Disease Control and Prevention) for detailed information regarding this virus. Further, I understand that my lack of inoculation with the Tdap vaccine may result in the refusal of a clinical placement based on individual clinical partnership contracts.</p> <p>Student Signature: _____</p> <p>Date: _____/_____/_____</p>

Healthcare Provider's Signature	
Name: _____	Certification: MD / NP / PA / RN
HCP Signature: _____	(Office Stamp)
Date: _____/_____/_____	