

# Whooping cough (Pertussis) Tdap Vaccination Permission Slip

**Child must have a signed permission slip or  
parents must be present to receive the vaccine.**

AGENCY NAME: Tehama County Health Services Agency – Public Health Division

DATE: \_\_\_\_\_ CHILD'S NAME: \_\_\_\_\_

AGE: \_\_\_\_\_ DOB: \_\_\_\_\_

MOTHERS FIRST NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

**REQUIRED:** Does your child have any of the following health coverage?

CHECK ONE:  Medi-Cal/CHDP  Healthy Families  Insurance Does Not Cover Vaccine  
 No Insurance  American Indian/Alaskan Native

**\*By signing this form you acknowledge:**

- You have received and reviewed the Tdap Vaccination Information Sheet.
- You authorize the use and disclosure of your child's immunization in the California Immunization Registry.
- You give permission for Tehama County Public Health to vaccinate your child with the whooping cough (pertussis) Tdap vaccine.

PARENT NAME: \_\_\_\_\_  
(Print)

PARENT SIGNATURE: \_\_\_\_\_  
(Sign)

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## Nurse Section

Vaccine lot#: _____	Date: _____
Site: _____	CAIR IZ # _____
RN: _____	