PLATT COLLEGE

# Standardized Immunization Form: Tdap Only

## Patient Section

| | | | | | |
|---|---|---|---|---|---|
| **Last Name:** | | **First Name:** | | **Middle Initial:** | |
| **DOB:** | | **Street Address:** | | | |
| **Last 4 SS#:** | | **City:** | | | |
| **Phone:** | | **State:** | | | |
| **Email:** | | **ZIP Code:** | | | |

## Below Section: MUST BE COMPLETED BY YOUR HEALTHCARE PROVIDER

| | |
|---|---|
| Printed Name of Healthcare Provider: | |
| Title: | |
| Address Line 1: | |
| Address Line 2: | |
| City: | |
| State: | |
| ZIP Code: | |
| Phone: | |
| Fax: | |
| Email Contact: | |

Authorized Signature of Healthcare Provider: _____

Date: _____

**Name:** _____ **Date of Birth:** _____

(Last, First, Middle Initial) (mm/dd/yyyy)

| **Tetanus-Diphtheria-Pertussis Vaccination** – One (1) dose of adult Tdap | | | |
|---|---|---|---|
| **Tetanus-Diphtheria-Pertussis Vaccination** | | Date | Documentation |
| | Tdap Vaccine (Adacel, Boostrix, etc) | _____/_____/_____ | |