Deansgrange Medical Centre
2 Clonkeen Road, Blackrock,
Co. Dublin.

Boostrix (Whooping Cough) Immunisation Consent Form

Patient's name & DOB: **(**place addressograph here)

Lot Number: **Expiry date:**

I have been fully informed about the above vaccine and which disease it provides protection against, the possible side effects, when they might occur and how they should be treated. I confirm by signing this form that I'm authorising consent for the administration of this vaccine to me.

Patient's signature: _____ Date: _____

Administered by: _____ Date: _____

Prescribed by: _____ Date: _____