

# Protect your child against tetanus, diphtheria and pertussis

For Grade 7 students



## Why your child should get the tetanus, diphtheria and pertussis (Tdap) vaccine...

- The Tdap vaccine protects against three diseases: tetanus (lockjaw), diphtheria and pertussis (whooping cough).
- Early childhood vaccines against pertussis (whooping cough) tend to wear off during adolescence.
- To help reduce the incidence of pertussis (whooping cough) in the population and protect babies that are not fully immunized.

## Who should get this vaccine?

Grade 7 students.

## Who should NOT get this vaccine?

- Individuals allergic to any part of the vaccine or its packaging.
- School age children who have already received a Tdap vaccine in the last five years.

## What you should know about tetanus, diphtheria and pertussis disease...

- **Tetanus** is caused by bacteria found in dirt, rust, manure and human feces. An individual becomes infected when bacteria enter an open cut.
- **Diphtheria** is caused by bacteria that infect the nose and throat. These bacteria release a poison that causes the disease symptoms. Diphtheria is spread by coughing and sneezing.
- **Pertussis** is caused by bacteria and begins like or in the same way as a cold. Pertussis is spread by coughing and sneezing.

## Possible Symptoms

Tetanus	Diphtheria	Pertussis
– muscle spasms	– breathing problems	– severe coughing
– convulsions	– heart failure	– choking
– sometimes death	– paralysis	– whooping cough
		– vomiting spells (lasting weeks or months)
		– sometimes death

## DID YOU KNOW?

The highest risk of death from pertussis (whooping cough) occurs in babies less than six months of age.



Mackenzie Couture (Saint Mary's Academy)

## What you should know about the Tdap vaccine...

### The vaccine...

- is **SAFE** and very effective in preventing disease;
- contains three separate vaccinations combined into one needle.

## What to expect following tetanus, diphtheria and pertussis immunization...

- **Common side effects** are pain, redness, and swelling at the injection site, mild headache, fever and body aches.

**Please note:** As is the case with any vaccine, there is a small risk that a serious allergic reaction can occur. **Therefore, students are asked to remain on site for at least 15 minutes after the vaccine is given so that possible immediate reactions can be monitored and treated.**

## How to treat fever and pain...

- A cold compress on the injection site may reduce discomfort.
- You may give your child *acetaminophen* (e.g., Tylenol®) or *ibuprofen* (e.g., Advil®).
- *Acetylsalicylic acid* (ASA or Aspirin®) should NOT be given to children younger than 18 due to its link to Reye's syndrome.

## What else you should know...

- If your child has a fever or illness other than a minor cold, the nurse may delay giving this vaccine.
- If your child's immune system is affected by illness, steroid medication or cancer treatments, the decision to immunize must be made in consultation with your family physician.
- It is important to record any allergies on the consent form.
- If your child has had an allergic reaction to a vaccine in the past, or if you have any questions, please contact your local Public Health office.
- Adverse reactions especially severe or unusual reactions in the four weeks following immunization should be reported to the local Public Health office. Please see your doctor if your child has a severe reaction.
- Further information is available at [www.gnb.ca/publichealth](http://www.gnb.ca/publichealth)

## How to register for this program...

- **Complete** and **sign** the consent section of the brochure.
- **Return** the completed consent section to the school *even if you choose not to have your child immunized.*
- **Keep** the rest of the brochure for your information.
- Once your child is immunized, the nurse will complete the immunization information on your child's **Personal Immunization Record** and return it to him or her.

## Consent form for tetanus, diphtheria and pertussis immunization

PLEASE COMPLETE AND RETURN THIS PORTION TO THE SCHOOL

School \_\_\_\_\_

Grade \_\_\_\_\_ Home room/teacher \_\_\_\_\_

Student's name \_\_\_\_\_ Birth date YYYY|MM|DD

Student's Medicare number \_\_\_\_\_  Male  Female

Daytime telephone number \_\_\_\_\_ Other daytime telephone number \_\_\_\_\_

**Allergies**  
 YES  NO Please specify \_\_\_\_\_

**Health Problems**  
 YES  NO Please specify \_\_\_\_\_

I have read or had explained to me the information on the vaccine, and I believe I understand its benefits, risks, side-effects and reasons why my child may or may not receive the vaccine. I have had the opportunity to ask questions to a health-care provider that were answered to my satisfaction.  
**Yes, I AGREE to allow my child to receive the tetanus, diphtheria and pertussis vaccination.**

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

No, **I DO NOT AGREE** to allow my child to receive the tetanus, diphtheria and pertussis vaccination.\*

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

\* Reason for refusal  
 Received within the last five years  Other \_\_\_\_\_

**Nurses Use Only**

Date	Vaccine Name	Manufacturer & Lot No.

Dose \_\_\_\_\_ Route/Site \_\_\_\_\_ Nurse's Initials \_\_\_\_\_



## Personal immunization record for tetanus, diphtheria and pertussis

Student's name \_\_\_\_\_ Birth date YYYY|MM|DD

Student's Medicare number \_\_\_\_\_

**This section is to be completed by the Public Health nurse**

Name of vaccine \_\_\_\_\_

Date immunized \_\_\_\_\_

Nurse's signature \_\_\_\_\_ Vaccination Time \_\_\_\_\_

This immunization record will be given to your child after his/her immunization. Please keep this record with your child's personal health files.