

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
<ul style="list-style-type: none"> muscle spasms convulsions sometimes death 	<ul style="list-style-type: none"> breathing problems heart failure paralysis 	<ul style="list-style-type: none"> severe coughing choking 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

How to register for this program...

- Complete** and **sign** the tear-off section of the brochure.
- Return** the completed tear-off 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.