

# Christian Liberty Academy

## Documentation of Tdap Administration

Student Name (Last, First, Middle) <div style="background-color: #e0e0e0; height: 20px; width: 100%;"></div>		
DATE of Tdap  ____ / ____ / _____	Name of Provider where Tdap was administered	
DATE OF BIRTH  <div style="background-color: #e0e0e0; height: 20px; width: 100%;"></div> ____ / ____ / _____	<b>*this form must be stamped by Provider here</b>	
Health Care Provider (MD, DO, APN, PA, health official, school health professional) verifying above immunization history must sign below:		
_____ Signature	_____ Title	_____ Date
_____ Print Name	(_____) _____ Phone Number	
_____ Address		