



FOR OFFICIAL USE:	
<input type="checkbox"/>	OSIIS
<input type="checkbox"/>	Original Shot Record
<input type="checkbox"/>	School Shot Record
<input type="checkbox"/>	No Record

IMMUNIZATION AUTHORIZATION

Last name		First Name		Middle Initial		Phone	
Address			City		State		Zip
Birthdate		Age	State of Birth	Social Security Number		Sex	
VFC Eligibility The child must be younger than 19 years of age and at least one of the following criteria must be met to qualify for immunizations at no charge. <input type="checkbox"/> My child has coverage through Soonercare/Medicaid # _____ <input type="checkbox"/> My child is American Indian or Native Alaskan <input type="checkbox"/> My child is uninsured.						Ethnicity (Please Check One) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander	
						Date	

I hereby consent to and request that the above named child receive the below marked immunizations provided by the Tulsa City-County Health Department and administered by medically trained health professionals.

I consent and understand that the below marked immunizations will be delivered with assistance from the Oklahoma Caring Foundation, Inc. and the Caring Van Program. I have read or had explained to me the information contained in the U.S. Department of Health and Human Service Vaccine Information Statement(s) about the below marked disease(s) and the below marked vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the below marked vaccine(s) and request that the below marked vaccine(s) be given to the above named child. I authorize disclosure of immunization information to the above named child care facility, school, public health officials and health care professionals.

I acknowledge that I have been given the opportunity to review the Tulsa City -County Health Department's Privacy Notice as required by the Health Insurance Portability and Accountability Act. A copy will be provided upon request.

This consent shall remain in effect for 90 days after the signed date.

Please check one of the following boxes:

- My child's immunizations **can be done without** my presence.
- My child's immunizations **can only be done with** my presence.

Signature of Parent or Legal Guardian 	PRINT Parent or Guardian's Name	Relationship to Child	Date
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<input type="checkbox"/> Please review my child's record and give any immunizations needed.				or			
<input type="checkbox"/> Select the immunizations you would like your child to receive below.							
Vaccine Name		Lot	Site	Vaccine Name		Lot	Site
<input type="checkbox"/> Diphtheria, Tetanus and Pertussis				<input type="checkbox"/> Measles, Mumps and Rubella			
<input type="checkbox"/> Polio				<input type="checkbox"/> Varicella (Chicken Pox)			
<input type="checkbox"/> Hepatitis B				<input type="checkbox"/> Tdap			
<input type="checkbox"/> Hepatitis A				<input type="checkbox"/> Td			
<input type="checkbox"/> Haemophilus Influenza Type B				<input type="checkbox"/> Meningococcal			
<input type="checkbox"/> Pheumococcal Conjugate				<input type="checkbox"/> Human Papillomavirus			
<input type="checkbox"/> Other				<input type="checkbox"/> Other			
SIGNATURE OF NURSE				Date			

