Oklahoma's Caring Vans

FOR OFFICIAL USE:
- ☐ OSIIS
- ☐ Original Shot Record
- ☐ School Shot Record
- ☐ No Record

IMMUNIZATION AUTHORIZATION

Last name	First Name	Middle Initial	Phone

Address	City	State	Zip	Mother's Maiden Name

Birthdate	Age	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.

- ☐ My child has coverage through Soonercare/Medicaid # _____
- ☐ My child is American Indian or Native Alaskan
- ☐ My child is uninsured.

Ethnicity (Please Check One)

☐ Hispanic ☐ Non-Hispanic

☐ White ☐ Black

☐ American Indian ☐ Alaskan Native

☐ Asian ☐ Pacific Islander

Date	Name of Child Care Center, School or Event

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

☐ Please review my child's record and give any immuniations needed.

or

☐ Select the immunizations you would like your child to receive below.

Vaccine Name	Lot	Site	Vaccine Name	Lot	Site
☐ Diptheria, Tetanus and Pertussis			☐ Measles, Mumps and Rubella		
☐ Polio			☐ Varicella (Chicken Pox)		
☐ Hepatitis B			☐ Tdap		
☐ Hepatitis A			☐ Td		
☐ Haemophilus Influenza Type B			☐ Meningococcal		
☐ Pheumococcal Conjugate			☐ Human Papillomavirus		
☐ Other			☐ Other		
SIGANATURE OF NURSE			**Date**		