Oklahoma's Caring Vans

TULSA HEALTH Department

OKLAHOMA CARING VAN PROGRAM/TULSA COUNTY HEALTH DEPARTMENT (THD) SEASONAL INFLUENZA CONSENT/AUTHORIZATION FORM

IN ORDER FOR THIS CONSENT/AUTHORIZATION TO BE VALID, IT MUST BE COMPLETED IN ITS ENTIRETY AND SIGNED BY A PARENT OR GUARDIAN.
PLEASE USE ONLY BLACK OR BLUE INK TO COMPLETE THIS FORM. ONLY FILL OUT AND RETURN IF YOU WANT YOUR CHILD TO HAVE AN INFLUENZA (FLU) SHOT.

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH / /	AGE	GENDER: ☐ FEMALE ☐ MALE
STREET ADDRESS		CITY		STATE	ZIP
PHONE NUMBER ( ) ☐ CELL ☐ HOME	LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER_____	ETHNICITY: HISPANIC ORIGIN? ☐ YES ☐ NO		RACE: ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐ WHITE	

VACCINES FOR CHILDREN (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.

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**.

THIS CONSENT SHALL REMAIN IN EFFECT FOR 90 DAYS AFTER THE DATE SIGNED

I, the undersigned, give my consent for myself or my child to receive the injectable influenza vaccination from the Tulsa Health Department with assistance from the Oklahoma Caring Vans Program. I have read or had explained to me the information contained in the Vaccine Information Statement(s) (VIS) about the disease(s) and the vaccine(s).I understand that the risks and benefits for these services will be explained to me and that I will have the opportunity to ask questions. I understand that I may refuse services at any time. I, the undersigned, do hereby authorize the Tulsa Health Department to release information from my or my child's immunization record to the following: healthcare providers, public health officials, schools, daycares, and the Department of Human Services. I acknowledge that I have been offered a copy of Tulsa Health Department Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act. I, the undersigned, authorize the release of any medical or other information necessary to process Medicare/Medicaid billing. I also request payment be assigned to the Tulsa Health Department. Medicare/Medicaid patients may receive a letter as part of Medicare/Medicaid's anti-fraud procedure. Please be aware that these letters are not seeking payment for services from patients.

SIGNATURE ➧	RELATIONSHIP TO CHILD	DATE

MEDICAL SCREENING QUESTIONS

HAVE YOU EVER HAD A FLU VACCINE? ☐ YES ☐ NO	DO YOU HAVE A FEVER, INFECTION OR CURRENT ILLNESS TODAY? ☐ YES ☐ NO	HAVE YOU EVER HAD A REACTION TO THE INFLUENZA VACCINE? ☐ YES ☐ NO	DO YOU HAVE AN ALLERGIC REACTION TO CHICKEN EGGS, LATEX, THIMEROSAL OR GELATIN? ☐ YES ☐ NO	HAVE YOU EVER EXPERIENCED GUILLAIN-BARRE SYNDROME (SEVERE PARALYTIC ILLNESS)? ☐ YES ☐ NO

FOR CLINIC USE ONLY — DO NOT WRITE BELOW THIS LINE

VACCINE TYPE	DATE	LOT NUMBER	SITE/ROUTE (ENTER NUMBER FROM KEY AT RIGHT)	SIGNATURE/INITIALS
FLUAFLURIA 9-18Y VFC				
FLUARIX 3-18Y VFC				
FLUZONE 6M-18Y VFC				
FLUZONE 3-18Y VFC				
FLUZONE 6-35M VFC				
FLUVIRIN 4-18Y VFC				
FLUARIX 3Y & UP				

SITE KEY:
1 RT Vast Lat IM
2 LT Vast Lat IM
3 RT Deltoid IM
4 LT Deltoid IM
9 Other (nasal spray)
13 RT Deltoid ID
14 LT Deltoid ID

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