Parental Consent for Immunization

No changes may be made to this form. All questions must be filled out for your child to participate.

Total Wellness staff initial when complete.

Entered in Core: _____ **Entered in OSIIS:** _____

School Name/Location: _____ **Teacher Name/Grade:** _____

Student Last Name	Student First Name	Student Middle Name	Student Birthday
			/ /

Male or Female (Circle One)	Birth Country	Birth State	English Spanish ASL Other (Primary Language Circle One)

Hispanic Non-Hispanic Other (Ethnicity Circle One)	( ) Parent/Guardian Phone Number	Foster Child ☐ Adopted Child ☐ Is the child a foster or adopted child?

Race: (Please Check One)
☐ American Indian/Alaskan Native ☐ Black/African American ☐ White
☐ Native Hawaiian/Other Pacific Islander ☐ Asian ☐ Other

Home Address	City	State	Zip Code

Insurance Company Name	Policy ID Number	Policy Group Number

Primary Insured Name & Relationship	Primary Insured Date of Birth	Mother's Maiden Name
	/ /	

Has your child ever had an allergic reaction to a vaccination, eggs, any medication or vaccine component?	Yes	No
If yes, please list reaction type:		
Has your child had any vaccinations in the last 8 weeks?	Yes	No
If yes, please list which vaccination(s):		
Does your child have sickle cell disease?	Yes	No
If yes, when was their last sickle cell crisis?	/ /	
If yes, have they had a fever or shortness of breath in the last 2 weeks?	Yes	No
Does your child have a history of cancer, leukemia, AIDS/HIV, a muscle/nervous system disorder, a seizure disorder, Gullain-Barre syndrome or any other immune sytem, autoimmune disorder or any other chronic or long-term condition?	Yes	No
If yes, please list:		
Has you child had aspirin daily, antiviral drugs, anticancer drugs, steroids for cancer, radiation therapy, immune/immune gamma globulin, a blood transfusion or any blood products in the past 8 weeks?	Yes	No
If yes, please list:		
For Females only Is there currently a chance she is pregnant?	Yes	No

Below are the immunizations offered today. **Please circle Yes or No** on each immunization listed for your child. ***If you are unsure which immunization is needed please leave blank.*** We will determine what vaccination is recommended by the State of Oklahoma & the Center for Disease Control (CDC) and then administer them to your child appropriately.

Tdap (Tetanus/Diptheria & Pertussis)	Yes	No	)	Yes	No
)	Yes	No	)	Yes	No

I consent and authorize my child to receive immunization(s) from Total Wellness without my physical presence. I am the legal parent/guardian to the above-named child. I understand that Total Wellness maintains the right to decline any immunization to the child listed above if he/she presents a risk of unintentional needle stick to staff or himself/herself. I have had a chance to read and ask questions in advance related to the benefits and the risk(s) of the vaccinations offered and acknowledge understanding. Please visit the CDC for the Vaccine Information Sheets on all vaccines offered at https://www.cdc.gov/vaccines/hcp/vis/current-vis.html. I hereby authorize the child listed above to have all immunizations the State of Oklahoma requires for entry into school and to receive the optional vaccines I have indicated by circling YES above. Total Wellness will release these records to the Oklahoma State Immunization Information System.

Parent/Guardian Signature: _____ **Date:** / /

<u>This page must be returned with the patient information side of the form.</u>

This side is to be completed by a Total Wellness member.

****<u>Initial below only when complete</u>****

Entered in OSIIS: _____ **Entered in Core:** _____

Child's Name: _____ **Date of Birth:** ___/___/___
First Name Last Name

Tdap	**VIS Revision Date 02/24/2015**
Manufacturer: _____ **Lot Number:** _____ **Expiration Date:** ___/___/___	
Intramuscular: ☐ **Subcutaneous:** ☐ **Right Arm:** ☐ **Left Arm:** ☐ **Right Thigh:** ☐ **Left Thigh:** ☐	
Gardasil	**VIS Revision Date 12/02/2016**
Manufacturer: _____ **Lot Number:** _____ **Expiration Date:** ___/___/___	
Intramuscular: ☐ **Subcutaneous:** ☐ **Right Arm:** ☐ **Left Arm:** ☐ **Right Thigh:** ☐ **Left Thigh:** ☐	
Meningococcal (A/C/W/Y)	**VIS Revision Date 08/24/2018**
Manufacturer: _____ **Lot Number:** _____ **Expiration Date:** ___/___/___	
Intramuscular: ☐ **Subcutaneous:** ☐ **Right Arm:** ☐ **Left Arm:** ☐ **Right Thigh:** ☐ **Left Thigh:** ☐	
Meningococcal (B)	**VIS Revision Date 08/09/2016**
Manufacturer: _____ **Lot Number:** _____ **Expiration Date:** ___/___/___	
Intramuscular: ☐ **Subcutaneous:** ☐ **Right Arm:** ☐ **Left Arm:** ☐ **Right Thigh:** ☐ **Left Thigh:** ☐	
Place Stickers Below (If Applicable)	

Administered By: _____ **Date:** ___/___/___
(Total Wellness Staff Signature)