

**FOR OFFICIAL USE:**

- ☐ OSIIS
- ☐ Original Shot Record
- ☐ School Shot Record
- ☐ No Record

IMMUNIZATION AUTHORIZATION

Last Name		First Name		Middle Initial	
Address		City	State	Zip	Phone
Birthdate	Age	Sex M - F	Language (Please Circle One) English Spanish		Ethnicity (Please Circle One) Hispanic Non- Hispanic
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.					Race (Please Circle One) White Black American Indian / Alaskan Native Asian / Pacific Islander
					Mother's Maiden Name

Date	Name of Child Care Center, School or Event
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I hereby consent to and request that the above named child receive the below marked immunizations provided by the Oklahoma City-County Health Department and administered by medically trained health professionals at the above named location.

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 Oklahoma 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 	Relationship to Child
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The above named child is due for, and will receive, the following vaccines:

- ☐ PLEASE CHECK MY CHILD'S RECORDS AND ADMINISTER ANY VACCINES(S) HE/SHE NEEDS.
- ☐ DTaP/Tdap Vaccine
- ☐ Hib Vaccine
- ☐ Hepatitis A Vaccine
- ☐ Hepatitis B Vaccine
- ☐ Pneumococcal Conjugate Vaccine
- ☐ Polio Vaccine
- ☐ Measles, Mumps and Rubella Vaccine
- ☐ Varicella (Chicken Pox) Vaccine
- ☐ Meningococcal Conjugate Vaccine