IMMUNIZATION AUTHORIZATION

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

LAST NAME	FIRST NAME	M.I.	PHONE

ADDRESS	CITY	STATE	ZIP	MOTHER'S MAIDEN NAME

BIRTHDATE	AGE	STATE OF BIRTH	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 ALASKA NATIVE

MY CHILD IS UNINSURED

ETHNICITY (PLEASE CHECK ONE)

HISPANIC	NON-HISPANIC
WHITE	BLACK
AMERICAN INDIAN	ALASKA NATIVE
ASIAN	PACIFIC ISLANDER

DATE	NAME OF CHILD CARE CENTER, SCHOOL OR EVENT	LANGUAGE

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.

OR

My child's immunizations can only be done *with* my presence.

Please check one of the following boxes:

Please review my child's record and give any immunizations neede d.

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		
HAEMOPHILUS INFLUENZA TYPE B			TD		
PHEUMOCOCCAL CONJUGATE			MENINGOCOCCAL		
HEPATITIS A			HUMAN PAPILLOMAVIRUS		
OTHER			OTHER		
SIGNATURE OF NURSE:			DATE:		
NOTES:					

SIGNATURE OF PARENT OR LEGAL GUARDIAN **X**	PRINT PARENT OR GUARDIAN'S NAME	RELATIONSHIP TO CHILD	DATE

Continued on back

Name/*Nombre*	Birth Date/*Fecha de nacimiento*

QUESTIONS FOR PERSON RECEIVING IMMUNIZATIONS			***PREGUNTAS PARA LA PERSONA QUE RECIBIRÁ LAS VACUNAS***		
1. Do you have fever, vomiting or diarrhea today?	☐ Yes	☐ No	1. *¿Hoy tiene fiebre, vómitos o diarrea?*	☐ Sí	☐ No
2. Do you have something more than a cold?	☐ Yes	☐ No	*2. ¿Está enfermo y es algo más que un resfriado?*	☐ Sí	☐ No
3. Are you taking medicine? If yes,what?	☐ Yes	☐ No	*3. ¿Está tomando algún medicamento? Si la respuesta es afirmativa, ¿cuál medicamento está tomando?*	☐ Sí	☐ No
4. Do you have allergies to any medication, food or vaccine? Eggs Gelatin Neomycin Latex Steptomycin Bakers Yeast Thimerosal	☐ Yes	☐ No	*4. ¿Es alérgico a algún medicamento, comida o vacuna?* *huevos gelatina neomicina* *látex estreptomicina* *levadura de panadería timerosal*	☐ Sí	☐ No
5. Have you had a serious reaction to a vaccine in the past? If yes, what kind of reaction?	☐ Yes	☐ No	*5. ¿Ha tenido anteriormente reacciones adversas a una vacuna? Si la respuesta es afirmativa, ¿en qué consistió esta reacción?*	☐ Sí	☐ No
6. Have you had any shots within the last three months? If yes, what shot?	☐ Yes	☐ No	*6. ¿Se le ha administrado alguna vacuna en los últimos tres meses? Si la respuesta es afirmativa, ¿cuál vacuna se le administró?*	☐ Sí	☐ No
7. Do you have or do you come in contact with anyone who has: Cancer Chemotherapy Leukemia Large does of steroids HIV/AIDS	☐ Yes	☐ No	7. *¿Tiene o ha entrado en contacto directo con alguien que tiene alguna de las siguientes enfermedades o recibe los siguientes tratamientos?* *cáncer quimioterapia* *leucemia grandes dosis de esteroides* *vih/sida*	☐ Sí	☐ No
8. Have you received blood, a blood product or immune(gamma) globulin in the last 12 months?	☐ Yes	☐ No	*8. ¿Ha recibido transfusiones de sangre, algún producto derivado de sangre o globulina inmune (gamma) en los últimos 12 meses?*	☐ Sí	☐ No
9. Have you had a seizure, brain or nerve problem?	☐ Yes	☐ No	*9. ¿Ha tenido convulsiones o algún problema neurológico?*	☐ Sí	☐ No
10. Have you had the disease Hepatitis A?	☐ Yes	☐ No	*10. ¿Ha padecido de Hepatitis A?*	☐ Sí	☐ No
11. Have you had the chickenpox? If yes, at what age?	☐ Yes	☐ No	*11. ¿Ha padecido de varicela? Si la respuesta es afirmativa, ¿a qué edad?*	☐ Sí	☐ No
12. Have you had the varicella (Chickenpox) vaccination?	☐ Yes	☐ No	*12. ¿Se le adminsitró la vacuna contra la varicela?*	☐ Sí	☐ No
13. Have you ever experienced Guillain-Barre Syndrome?	☐ Yes	☐ No	13 *¿Ha padecido del Síndrome de Guillain-Barré?*	☐ Sí	☐ No
14. For Females 10 years of age and older: are you pregnant or planning a pregnancy?	☐ Yes	☐ No	*14. Mujeres mayores de 10 años: ¿Está embarazada o está planificando quedar embarazada?*	☐ Sí	☐ No
15. Where did you hear about this clinic? (Check One) TV Radio Newspaper School Flier Family or Friend Other _____			*15. ¿Cómo supo de esta clínica? (Marque uno)* *TV radio periódico escuela familiar o amigo* *otro* _____		

SIGNATURE OF PARENT OR LEGAL GUARDIAN / *FIRMA DEL PADRE, MADRE O TUTOR*	PRINT PARENT OR GUARDIAN'S NAME / *NOMBRE DEL PADRE, MADRE O TUTOR*	RELATIONSHIP TO CHILD / *PARENTESCO CON EL MENOR*	DATE / *FECHA*
X			

Vaccine Information Statements available at ***immunize.org/vis/***
Declaración de información sobre la vacuna (VIS) disponible en ***immunize.org/vis/***

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