# General Vaccine Consent Form

**oklahomacaringfoundation.org**

| | | | | |
|---|---|---|---|---|
| Last name: | First name: | | Date of Birth: (month-day-year) | |
| Address: | City: | | State: | Zip code: |
| Phone number: | Age: | Sex: | Language: | |

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 vaccines at no charge:

- ☐ My child has SoonerCare/Medicaid
- ☐ My child is American Indian or Alaskan Native
- ☐ My child is uninsured

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race:

- ○ America Indian/Alaskan Native
- ○ Asian
- ○ Black or African American
- ○ Native Hawaiian/Pacific Islander
- ○ White
- ○ Other

| | |
|---|---|
| Date: | Name of Childcare Center, School, or Event: |

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

Please check one of the following boxes:

- ☐ Please review my child's record and give any immunizations needed
- ☐ Select the immunizations you would like your child to receive below:

Please write in or circle: _____

| DTaP | Hep B | IPV | Hep A | HIB | PCV | Rota | MMR | Varicella | HPV | Tdap | MCV | Men B |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

I am the parent/guardian/authorized party for the patient. I give permission to Variety Care and the Oklahoma Caring Foundation to give the vaccine(s) to my child. To the best of my knowledge, the information above and the screening questions are correct. I have had the opportunity to review the VIS (Vaccine Information Statement). I give my full, informed consent for the vaccine(s). I authorize disclosure of immunization information to the above-named childcare facility, school, public health officials, and health care professionals. This consent shall remain in effect for 90 days after the signed date.

**VIS →**

**Signature: _____ Date: _____**

**Print name: _____ Relationship to Child: _____**



**Continued on back →**

| Screening Questions for Person Receiving Vaccines: | YES | NO | Don't Know |
|---|---|---|---|
| 1. Are you sick today? | | | |
| 2. Do you have an allergy to eggs, medications, a vaccine component, or latex? | | | |
| 3. Have you ever had a serious reaction after receiving a vaccine? | | | |
| 4. Do you have a history of a blood disorder with low platelets? Are you taking aspirin? | | | |
| 5. For babies: Have you ever been told the child had intussusception? | | | |
| 6. Have you (the child, a sibling or a parent) ever had a seizure or other brain or nervous system problem (including Guillain-Barré syndrome)? | | | |
| 7. Do you (or the child or a family member) have cancer, leukemia, HIV/AIDS, or any other immune system problem? | | | |
| 8. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? | | | |
| 9. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug? | | | |
| 10. Is the person receiving vaccines pregnant or planning to become pregnant? | | | |
| 11. Have you received vaccinations in the past 4 weeks? | | | |
| If "yes" to any answer above, please explain: | | | |

**DO NOT WRITE BELOW THIS LINE**

---

**VARIETY CARE STAFF COMPLETION ONLY:**

| | | |
|---|---|---|
| Vaccine name: | Lot number: | Site: |
| Vaccine name: | Lot number: | Site: |
| Vaccine name: | Lot number: | Site: |
| Vaccine name: | Lot number: | Site: |
| **X**_____<br>**Signature of Person Administering Vaccine** | | Date: |