Oklahoma's Caring Vans

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

IMMUNIZATION AUTHORIZATION

Last name	First Name	Middle Initial	Phone	
Address	**City**	**State**	**Zip**	**Mother's Maiden Name**
Birthdate / **Age**	**Social Security Number**	**Sex**	**Ethnicity (Please Check One)**	

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.

Ethnicity (Please Check One)

□ Hispanic □ Non-Hispanic

□ White □ Black

□ American Indian □ Alaskan Native

□ Asian □ Pacific Islander

Date	Name of Child Care Center, School or Event

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

Signature of Parent or Legal Guardian	PRINT Parent or Guardian's Name	Relationship to Child	Date

☐ Please review my child's record and give any immuniations needed.

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		
☐ Hepatitis A			☐ Td		
☐ Haemophilus Influenza Type B			☐ Meningococcal		
☐ Pheumococcal Conjugate			☐ Human Papillomavirus		
☐ Other			☐ Other		
SIGANATURE OF NURSE			**Date**		

Name_____ Birth Date_____

Nombre *Fecha de Nacimiento*

Questions for Person Receiving Immunizations

Preguntas Para la Persona Recibiendo Las Vacunas

1. **Do you have fever, vomiting or diarrhea today?** *¿Tien calenture, vómito o diarrhea hoy?*	Yes	No
2. **Do you have something more than a cold?** *¿Esta enfermo con algo mas que un resfriado?*	Yes	No
3. **Are you taking medicine?** *¿Esta tomando alguna medicina?*	Yes	No
4. **Do you have allergies to any medication, food or vaccine?** *¿Tiene alergia a un medicamento, comida a vacuna?* Circle to indicate allergy: *Indique si es alergico a uno de lo siguiente:* Eggs *Huevos* Latex Latex Bakers Yeast *Lavadrua de cocinar* Gelatin *Gelatina* Neomycin *Neomicina* Steptomycin *Estreptomicina* Thimerosal *Timerosal*	Yes	No
5. **Have you had a serious reaction to a vaccine in the past?** *¿Ha tenido anteriormente reacciones severas a una vacuna?*	Yes	No
6. **Have you had any shots within the last three months?** *¿Ha recibido alguna vacuna en los últimos tres meses?*	Yes	No
7. **Do you have or do you come in contact with anyone who has:** *¿Tiene o esta teniendo contacto directo con alguien que tiene?* Cancer *Cancer* Leukemia *Leucemia* HIV/AIDS *VIH/SIDA* Chemotherapy *Recibiendo Quimioterapia* Large does of steroids *Recibiendo grandes dosis de esteroides*	Yes	No
8. **Have you received blood, a blood product or immune(gamma) globulin in the last 12 months?** *¿Ha recibido transfusionde sangre,producto de sangre o globulina (gamman) immune en los últimos 12 mes?*	Yes	No
9. **Have you had a seizure, brain or nerve problem?** *¿Hatenido una convulsi ón, problemas de nervio ode cerebro?*	Yes	No
10. **Have you had the disease Hepatitis A?** *¿Le ha dado la enfermedad de la Hepatitis A?*	Yes	No
11. **Have you had the chickenpox? If yes, at what age? _____** *¿Ha tenido la enfermedad de la varicela? A que edad?* **_____**	Yes	No
12. **Have you had the varicella (Chickenpox) vaccination?** *¿Ha recibidola vacuna para la varicela?*	Yes	No
13. **Have you ever experienced Guillain-Barre Syndrome?** *¿Ha tenido el Sindrome de Guillain-Barre?*	Yes	No
14. **For Females 10 years of age and older: are you pregnant or planning a pregnancy?** *¿Para mujeres mayors de 10 años; esta emarazada o esta planeando un embarazo?*	Yes	No
15. **Where did you hear about this clinic? (Circle One**) *¿C ómo supo de esta clinica? (Circle Uno)* TV Radio Newspaper/Periódico School Flier/Escuela Family or Friend/Familiar o Amistad Other _____	Yes	No