Oklahoma State Department of Health/Choctaw Nation
Influenza Vaccination Partnership
Consent Form

Last Name: _____ **First Name:** _____ **MI:**____ **Date of Service:**_____

Date of Birth: ____ ____ ____ **Birth State:** _____ **Gender:** ☐ Male ☐ Female

Month Day Year

Age: ____ **Grade:**____

Race (circle all that applies)
1 - Black
2 - Hispanic
3 - Asian/Pacific Islander
4 - American Indian/Alaskan Native
5 - White

Mothers Maiden Name: _____

Address : _____ **City:** **State:** **Zip:**

Phone 1: _____ HOME **Phone 2:** _____ CELL

Guardian Last Name (For children only): _____ **Guardian First Name:** _____

Please circle one: Private Insurance (Policy/Group #):_____ **Medicare (# including letter):**_____
Medicaid (#):_____ **No Insurance**

PLEASE ANSWER THE FOLLOWING QUESTIONS:

	YES	NO
1. Is the person to be vaccinated sick today?	☐	☐
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barré Syndrome within 6 weeks after receiving a flu vaccine?	☐	☐
5. My child may receive this vaccine without my presence. I understand if my child is not cooperative, the vaccine will not be administered.	☐	☐

I have read or had explained to me the information contained in the 2017-2018 Vaccine Information Sheet for the 2017 influenza seasonal vaccine. I have had the chance to ask questions which have been answered to my satisfaction. I understand the benefits and risks of the seasonal influenza vaccine and consent to receive the seasonal influenza vaccine for myself or my child (if applicable). I understand that this vaccination will be recorded in the Oklahoma State Immunization Information System (OSIIS). If this vaccination is provided to my child in a childcare/school setting, I give my consent for Oklahoma State Department of Health/ Choctaw Nation to administer Influenza Vaccine to my child and disclosure of this vaccination information to the childcare/school setting.

Signature:_____**Date:**_____

OFFICE USE ONLY-DO NOT WRITE BELOW

Vaccine:_____ Lot # _____ Nurse's Signature:_____Nurse's Initials_____

VFC Vaccine: __ Flulaval___ Lot #_ FJ47F_____

Site Given: Afluria Fluarix:

RVL=1 LVL= 2 RD = 3 LD = 4 01144611A LN2GZ