



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: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Address: \_\_\_\_\_

Phone 1: \_\_\_\_\_ HOME Phone 2: \_\_\_\_\_ CELL

Guardian Last Name (For children only): \_\_\_\_\_ Guardian First Name: \_\_\_\_\_

Please circle one: Private Insurance Medicare Medicaid No Insurance

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**

- School vaccines only: I do not want my child vaccinated unless I am present (a yes answer means your child will not be vaccinated unless you are in attendance). YES  NO
- Is the person to be vaccinated sick today?
- Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?
- Has the person to be vaccinated ever had Guillain-Barré Syndrome within 6 weeks after receiving a flu vaccine?
- Does the person to be vaccinated have an allergy to a component of the vaccine?

I have read or had explained to me the information contained in the 2018-2019 Vaccine Information Sheet for the 2018 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. **I understand if my child is not cooperative, the vaccine will not be administered.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OFFICE USE ONLY-DO NOT WRITE BELOW**

Vaccine: \_\_\_\_\_ Lot # \_\_\_\_\_ Nurse's Signature: \_\_\_\_\_ Nurse's Initials \_\_\_\_\_  
 VFC Vaccine: \_\_\_\_\_  
 Site Given: \_\_\_\_\_  
 RVL=1 LVL= 2 RD = 3 LD = 4