Oklahoma's Caring Vans

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

IMMUNIZATION AUTHORIZATION

Last Name	**First Name**	**Middle Initial**

Address	**City**	**State**	**Zip**	**Phone**

Birthdate	**Age**	**Sex**	**Language** *(Please Circle One)*	**Ethnicity**
		M - F	English Spanish	Hispanic Non- Hispanic

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.**

Race

White Black

American Indian / Alaskan Native

Asian / Pacific Islander

Mother's Maiden Name

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 Oklahoma City-County Health Department and administered by medically trained health professionals at the above named location.

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 Oklahoma 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	**Relationship to Child**

The above named child is due for, and will receive, the following vaccines:

- ☐ **PLEASE CHECK MY CHILD'S RECORDS AND ADMINISTER ANY VACCINES(S) HE/SHE NEEDS**

- ☐ DTaP/Tdap Vaccine
- ☐ Hib Vaccine
- ☐ Hepatitis A Vaccine
- ☐ Hepatitis B Vaccine
- ☐ Pneumococcal Conjugate Vaccine
- ☐ Polio Vaccine
- ☐ Measles, Mumps and Rubella Vaccine
- ☐ Varicella (Chicken Pox) Vaccine
- ☐ Meningococcal Conjugate Vaccine
- ☐ Human Papillomavirus Vaccine

Patient Name: _____

DOB: _____

PHOCIS#_____

CHILDREN'S IMMUNIZATION QUESTIONNAIRE

		Yes/Si	No
1	Does your child have a fever today? Tiene su niño fiebre hoy?		
2.	Is your child sick with anything more than a cold? Está su niño/a enfermo/a con algo más que un resfriado?		
3.	Is your child taking any medications, including chemotherapy or large doses of steroids? Está su niño tomando alguna medicina incluyendo quimioterapia o grandes dosis de esteroides?		
4.	Does your child have any allergy to any of the following? If yes please circle: Bakers' yeast Gelatin Neomycin Streptomycin Thimerosal (mercury derivative) Latex Es alérgico su niño a algo de lo siguiente? Si su respuesta es si, por favor circúlela Levadura para hornear Gelatina Neomicina Estreptomicina Thimerosal (derivado del mercurio) Látex		
5.	Has your child had any reactions to vaccines in the past? Ha tenido su niño alguna reacción a las vacunas en el pasado?		
6.	Has your child received any vaccinations within the last 3 months? Ha recibido su niño alguna vacuna en los últimos 3 meses?		
7.	Has your child ever had a seizure? Ha tenido su niño alguna vez una convulsión (ataque)?		
8.	Does your child have any of the following? If yes, please circle: Cancer Leukemia HIV/AIDS SCID (Severe combined immunodeficiency disease) Tiene su niño algo de lo siguiente? Si su respuesta es si, por favor circúlela: Cáncer Leucemia VIH/SIDA Enfermedad inmunodeficiente severo combinada		
9.	Is your child in close contact with anyone that has any of the following? If yes, please circle Cancer Leukemia Chemotherapy Large doses of steroids HIV/AIDS Está su niño en contacto cercano con alguien que tenga algo de lo siguiente? Si su respuesta es si, por favor circúlela: Cáncer Leucemia Quimioterapia Grandes dosis de esteroides VIH/SIDA		
10	Has your child received a blood tranfusion or any other blood products in the past 3 months? Ha recibido su niño una trasfusión de sangre o algún otro producto sanguíneo en los últimos 3 meses		
11.	Has your child had a Tuberculosis (TB) skin test in the past 4 weeks? Ha tenido su niño una prueba cutánea (piel) para Tuberculosis (TB) en las últimas 4 semanas?		
12.	Will your child need a Tuberculosis (TB) skin test in the next 6 weeks? Va a necesitar su niño una prueba cutánea (piel) para Tuberculosis (TB) en las próximas 6 semanas?		
13.	Has your child had chickenpox disease? Ha tenido su niño la varicela?		
14.	**FOR GIRLS OVER AGE 12 ONLY - - - - - Is your child be pregnant? Para niñas (mayores de 12 años de edad)- - - - - - - esta su niña embarazada?**		

Form Completed by: X_____ Date: _____

Form Reviewed by:_____ Date: _____