

COVID-19/Flu Vaccine Consent Form

Please print information about the patient to receive vaccine

CLIENT INFORMATION					
PATIENT'S NAME (Last)		(First)		(M.I.)	SUFFIX (eg. Jr, III)
DATE OF BIRTH (MM/DD/YYYY)		AGE [†]		PHONE () <input type="checkbox"/> Cell <input type="checkbox"/> Home	
ADDRESS			CITY		STATE
SEX AT BIRTH <input type="checkbox"/> Female <input type="checkbox"/> Male	GENDER IDENTITY (optional) <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-binary <input type="checkbox"/> Unknown <input type="checkbox"/> Prefer not to say			Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic/Latino	
RACE <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other					

FOR CHILD UNDER 18 OR ADULT CONSERVATEE ONLY

VFC Eligibility <i>The child must be younger than 19 years of age and meet at least one of the following criteria to qualify for Influenza vaccination at no charge.</i> <input type="checkbox"/> My child has coverage through Soonercare/Medicaid <input type="checkbox"/> My child is American Indian or Native Alaskan <input type="checkbox"/> My child is uninsured	
Guardian relationship to client: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other I understand that the COVID-19 vaccine is a voluntary vaccine currently being given under the Emergency Use Authorization status and only a parent or legal guardian has the authority to consent to a minor or adult conservatee receiving this vaccine. By signing this form, I certify that I have the legal authority to do so on behalf of the patient identified above and will indemnify Oklahoma City-County Health Department against challenges to this consent or my status as legally able to provide consent for this vaccine.	
Guardian Printed Name _____ Mother's Maiden Name _____ (required for children under 18 only) Guardian's State or Federally issued ID # _____ (incl. State License, Passport, Consulate Card, etc.)	
Please check one: <input type="checkbox"/> My child/adult conservatee can be vaccinated without my presence. <input type="checkbox"/> My child/adult conservatee can <i>only</i> be vaccinated in my presence.	

I understand that should I have any questions about the COVID-19 vaccine, need assistance filling out this form, or need any other information regarding COVID-19, I can contact the Oklahoma City County Health Department at (405) 425-4489 prior to signing this form or at the vaccine distribution location.

CONSENT VACCINATION AND RELEASE OF VACCINATION INFORMATION:

I, the undersigned, give consent as the patient or for the patient listed above to receive the services requested from the Oklahoma City-County Health Department (heretofore "OCCHD") and certify that I am either the patient or that I have legal authority to consent to these services on behalf of the patient.

I authorize disclosure of this vaccination information to public health officials, other healthcare professionals, schools, daycares, and the Department of Human Services. I understand that record of these services will be recorded in the Oklahoma State Immunization Information System (OSIIS) for the purposes of sharing vaccination information with other healthcare providers and tracking vaccine inventory only. A record of these services will also be entered into OCCHD's Management Information Systems, as necessary.

I authorize release of any medical or other information appropriate to process Medicare/Medicaid billing, as required, and request payment be assigned to the OCCHD.

I acknowledge that I can access a copy of OCCHD's HIPPA Privacy Notice as required by the Health Information Portability and Accountability Act (HIPPA) at <https://www.occhd.org/about/contact-us/hippa>.

I have read or had explained to me the *Emergency Use Authorization (EUA) or Vaccine Information Sheet (VIS)* for the vaccines I am requesting. I have had a chance to ask questions which have been answered to my satisfaction. I believe I understand the benefits and risks of the services I am requesting for the patient. I understand that I, or the patient, may refuse services at any time.

I acknowledge that for health and safety reasons masks must be worn at all times during a vaccination event. By signing this form, I acknowledge this requirement and agree that I, my child, and/or my adult conservatee will wear a mask during the vaccination process with OCCHD.

In the event of an emergency, I authorize OCCHD to administer emergency medication (Epinephrine/Benadryl) to the patient and to obtain any necessary medical care including, but not limited to, paramedic assistance and transport to a local hospital for additional treatment or observation.

Signature of Patient/Parent/Guardian _____ Date: _____

Continued on Back

Client Name (Last, First, MI) _____, _____, _____ Client DOB (MM/DD/YYYY) _____

Screening for Vaccine Eligibility	YES	NO	UNKNOWN
GENERAL QUESTIONS			
Is the patient sick today?			
Does the patient have a history of Guillian-Barré Syndrome (GBS)?			
2021-2022 SEASONAL INFLUENZA VACCINATION			
Does the patient have an allergy to eggs or another component of the vaccine?			
Has the patient ever had a serious reaction to an influenza vaccine in the past?			
COVID-19 VACCINATION			
Has the patient ever received a dose of the COVID-19 Pfizer-BioNTech vaccine? <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson) <input type="checkbox"/> Another Product: _____ Dose 1 Date: _____ Dose 2 Date: _____			
Has the patient ever had an allergic reaction to: <input type="checkbox"/> a component of a COVID-19 vaccine, including either of the following: - polyethylene glycol (PEG), which is found in some medications, such as laxatives and preps for colonoscopy procedures - polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids <input type="checkbox"/> a previous dose of COVID-19 vaccine <input type="checkbox"/> a vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 component, but it is not known which component elicited the immediate reaction <input type="checkbox"/> another vaccine (other than COVID-19 vaccine) or an injectable medication?			
Has the patient ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
Does the patient have a history of myocarditis or pericarditis?			
Has the patient ever had COVID-19 and been treated with monoclonal antibodies or convalescent plasma?			
Has the patient ever been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?			
Does the patient have a bleeding disorder or take a blood thinner?			
Does the patient have a history of heparin-induced thrombocytopenia (HIT)?			
Does the patient have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies?			
Has the patient ever received dermal fillers?			
If receiving a third/booster dose of a COVID-19 vaccine, I attest that the patient is eligible for third/booster dose vaccination during this event under the current CDC guidelines.			

OFFICE USE ONLY – DO NOT WRITE BELOW

Ask before administration: Is the client pregnant or breastfeeding? <input type="checkbox"/> Y <input type="checkbox"/> N		
VFC Status: <input type="checkbox"/> 0-Not Eligible <input type="checkbox"/> 1-Medicaid <input type="checkbox"/> 2-Native American <input type="checkbox"/> 3-Native Alaskan <input type="checkbox"/> 4-Underinsured <input type="checkbox"/> 5-No Insurance <input type="checkbox"/> 6-Private Insurance		
COVID-19 Vaccine Mfr: Lot #: Exp. Date:	Site: <input type="checkbox"/> LT DELTOID IM <input type="checkbox"/> RT DELTOID IM <input type="checkbox"/> LT VAST LAT IM <input type="checkbox"/> RT VAST LAT IM	Dose Number: <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd EUA* given? <input type="checkbox"/> Y <input type="checkbox"/> N EUA Dated: _____
Influenza Vaccine Mfr: Lot #: Exp. Date:	Site: <input type="checkbox"/> LT DELTOID IM <input type="checkbox"/> RT DELTOID IM <input type="checkbox"/> LT VAST LAT IM <input type="checkbox"/> RT VAST LAT IM	VIS given? <input type="checkbox"/> Y <input type="checkbox"/> N VIS Dated: _____

Provider Signature: _____