



**Oklahoma State Department of Health/Chickasaw Nation
Influenza Vaccination Partnership**



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

Date of Birth: _____ **Gender:** Male Female

Month Day Year

Mother's Maiden Name: _____

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

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

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

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

Please circle one: Private Insurance (Policy/Group #): _____ **Medicare (# including letter):** _____

Medicaid (#): _____ **No Insurance**

PLEASE ANSWER THE FOLLOWING QUESTIONS:

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. I understand if my child is not cooperative, the vaccine will not be administered.
6. My child may receive this vaccine without my presence.

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

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/ Chickasaw Nation to administer Influenza Vaccine to my child and disclosure of this vaccination information to the childcare/school setting.

Signature: _____ **Date:** _____ **Time:** _____

OFFICE USE ONLY - DO NOT WRITE BELOW

Vaccine: _____ Lot # _____ Nurse (Print Name) : _____ Signature: _____
 VFC Vaccine: _____ Lot # _____ Date/Time: _____
 Site Given: RVL=1 LVL= 2 RD = 3 LD = 4