COVID-19/Flu Vaccine Consent Form

Please print information about the client to receive vaccine.

Client Information			Date of Service:
CLIENT'S NAME (Last)	(First)	(M.I.)	SUFFIX (Jr., III)
DATE OF BIRTH (mm/dd/yyyy)	**AGE†**	**PHONE** ☐ Cell ☐ Home ☐ Other	Can we call you at this number? ☐ Yes ☐ No
ADDRESS	**CITY**	**STATE** **ZIP CODE**	Can we mail you if necessary? ☐ Yes ☐ No

GENDER (at birth) ☐ Male ☐ Female ☐ Other
Is your gender identity different than marked above? ☐ Yes ☐ No

BIRTH STATE ☐ Oklahoma ☐ Other (specify):

RACE(s) ☐ American Indian/Alaskan Native ☐ Black/African American ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Asian ☐ Other

ETHNICITY ☐ Hispanic/Latino ☐ Not Hispanic/Latino

MARITAL STATUS ☐ Single ☐ Widowed ☐ Married ☐ Legally Separated ☐ Divorced ☐ Living Together (not married) ☐ Other

INSURANCE ☐ Soonercare/Medicaid ☐ Medicare ☐ BlueCross/BlueShield ☐ HealthChoice ☐ No Insurance ☐ Other (specify):

FOR CHILD UNDER 18 OR ADULT CONSERVATEE ONLY

VFC Eligibility *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.*

☐ My child has coverage through Soonercare/Medicaid
☐ My child is American Indian or Native Alaskan
☐ My child is uninsured

Guardian relationship to client: ☐ Mother ☐ Father ☐ Guardian ☐ **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:
☐ My child/adult conservatee can be vaccinated **without** my presence.
☐ My child/adult conservatee can ***only*** be vaccinated in my presence.

Name of person bringing client on your behalf (Last, First)

CONSENT FOR SERVICE

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) 419-4200 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 (hereto after "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:________________

CLIENT NAME (Last, First, MI): **DATE OF BIRTH:** **MRN:**

Screening for Vaccine Eligibility	YES	NO	UNKNOWN
GENERAL QUESTIONS			
Is the patient sick today?			
Does the patient have a history of Guillain-Barré Syndrome (GBS)?			
2023-2024 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 vaccine? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another Product: ______________ How many COVID-19 vaccine doses has the patient received? ______________________________ Date of most recent COVID-19 vaccination: ______________________________			
Does the patient have a history of COVID-19 disease within the past 3 months?			
Has the patient ever had an allergic reaction to: ☐ 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 ☐ a previous dose of COVID-19 vaccine ☐ another vaccine (other than COVID-19 vaccine) or an injectable medication?			
Does the patient have a history of myocarditis or pericarditis?			
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 (including history of an immune-mediated syndrome defines by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia, or a history of thrombosis with thrombocytopenia syndrome)?			
Has the patient received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?			
Does the patient have a health condition or is the patient undergoing treatment that makes them moderately or severely immunocompromised? (i.e., HIV infection, cancer, recipient of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, HCT, or moderate or severe primary immunodeficiency)			
I attest the patient is eligible under the current CDC guidelines to receive the vaccine dose being requested today.			

OFFICE USE ONLY – DO NOT WRITE BELOW

Ask before administration: Is the client pregnant or breastfeeding? ☐ Y ☐ N

VFC STATUS ☐ 01-Not Eligible ☐ 02-Medicaid ☐ 03-No Insurance ☐ 04-American Indian/Alaskan Native ☐ 05-Underinsured ☐ 06-Private Insurance

Private Insurance: ☐ BCBS ☐ HealthChoice ☐ Medicare-Part B (Covers Flu/Hep B/Pneumococcal) ☐ Other

COVID-19 Vaccine

Mfr: ______________________

Lot #: ______________________

Exp. Date: ______________________

Site:

☐ LT DELTOID IM ☐ RT DELTOID IM

☐ LT VAST LAT IM ☐ RT VAST LAT IM

Dose (mL): ____________________

EUA given? ☐ Y ☐ N

EUA Dated: ____________________

Vaccine: ☐ Pfizer 6mos-4yrs (Maroon cap & label) ☐ Moderna 6mos-5yrs (Pink cap/yellow label)
☐ Pfizer 5yrs-11yrs (Orange cap & label) ☐ Moderna 6mos-5yrs (Pink cap/yellow label)
☐ Pfizer 12yrs+ (Gray cap & label)

Influenza Vaccine

Mfr: ______________________

Lot #: ______________________

Exp. Date: ______________________

Site:

☐ LT DELTOID IM ☐ RT DELTOID IM

☐ LT VAST LAT IM ☐ RT VAST LAT IM

VIS given? ☐ Y ☐ N

VIS Dated: ____________________

Funding: ☐ Private Pay
☐ 317
☐ VFC

Vaccine: ☐ Fluarix QD
☐ Fluzone QD
☐ Fluzone High Dose
☐ Flucelvax QD

Provider Signature: Date: