2017 – 2018 Seasonal Influenza Consent OSIIS Data Entry Form

PHOCIS

Last Name	First Name	Middle Initial	Date of Birth
			__ __ - __ __ - __ __ __ __
Street Address	**City**	**State**	**Zip**
Gender Male ☐ Female ☐	**Ethnicity** Hispanic Origin Yes ☐ No ☐	**Phone Number** ( ) _____ - _____	
Race White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander ☐			
Mother's Maiden Name Needed for children under age 18 only	**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.**		

Please complete the following screening questions: The following questions will help us determine if there is any reason you should not receive an influenza vaccine:

- Is the person to be vaccinated sick today? YES_____ NO_____ I DON'T KNOW_____
- Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? YES_____ NO_____ I DON'T KNOW_____
- Has the person to be vaccinated ever had a serious reaction to an influenza vaccine in the past? YES_____ NO_____ I DON'T KNOW_____
- Has the person to be vaccinated ever had Guillain-Barre syndrome? YES_____ NO_____ I DON'T KNOW_____

I, the undersigned, give my consent for myself or my child to receive vaccinations from the Oklahoma City-County Health Department. I understand that the risks and benefits for these services will be explained to me and that I will have the opportunity to ask questions. I understand that I may refuse services at any time. I, the undersigned, do hereby authorize the Oklahoma City-County Health Department to release information from my or my child's immunization record to the following: healthcare providers, public health officials, schools, daycares, and the Department of Human Services. I acknowledge that I have been offered a copy of Oklahoma City-County Health Department Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act. I, the undersigned, authorize the release of any medical or other information necessary to process Medicare/Medicaid billing. I also request payment be assigned to the Oklahoma City-County Health Department. Medicare/Medicaid patients may receive a letter as part of Medicare/Medicaid's anti-fraud procedure. Please be aware that these letters are not seeking payment for services from patients.

Signature of patient or parent/legal guardian: _____ Date: _____

Printed name of patient or parent/legal guardian: _____

For Clinic Use Only – Do Not Write In Grey Areas

VFC Status: 0 – Not Eligible ☐ 1 – Medicaid ☐ 2 – Native America ☐ 3 – Native Alaskan ☐ 4 – Underinsured ☐ 5 – No Insurance ☐ 6 – Private Insurance ☐

Date Given	Given By (First Initial, Last Name)	Vaccine Name in OSIIS	Lot Number	Site/Route (Circle number on line next to vaccine) 1- RT Vast Lat IM 2- LT Vast Lat IM 3- RT Deltoid IM 4- LT Deltoid IM 13-RT Deltoid ID 14-LT Deltoid ID
		Injection – 1398		1 2 3 4 13 14