



IMMUNIZATION AUTHORIZATION

oklahomacaringfoundation.org



LAST NAME		FIRST NAME		M.I.	PHONE
ADDRESS		CITY	STATE	ZIP	MOTHER'S MAIDEN NAME
BIRTHDATE	AGE	STATE OF BIRTH	SEX		ETHNICITY (PLEASE CHECK ONE) <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> AMERICAN INDIAN <input type="checkbox"/> ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> PACIFIC ISLANDER
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. <input type="checkbox"/> MY CHILD HAS COVERAGE THROUGH SOONERCARE/MEDICAID # _____ <input type="checkbox"/> MY CHILD IS AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> MY CHILD IS UNINSURED					
DATE	NAME OF CHILD CARE CENTER, SCHOOL OR EVENT		LANGUAGE		

I hereby consent to and request that the above-named child receive the below marked immunizations provided by Variety Care and administered by medically trained health professionals.

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 Variety Care 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.

OR

My child's immunizations can only be done *with* my presence.

Please check one of the following boxes:

Please review my child's record and give any immunizations needed.

OR

Select the immunizations you would like your child to receive below.

VACCINE NAME	LOT	SITE	VACCINE NAME	LOT	SITE
<input type="checkbox"/> DIPHTHERIA, TETANUS AND PERTUSSIS			<input type="checkbox"/> MEASLES, MUMPS AND RUBELLA		
<input type="checkbox"/> POLIO			<input type="checkbox"/> VARICELLA (CHICKEN POX)		
<input type="checkbox"/> HEPATITIS B			<input type="checkbox"/> TDAP		
<input type="checkbox"/> HAEMOPHILUS INFLUENZA TYPE B			<input type="checkbox"/> TD		
<input type="checkbox"/> PHEUMOCOCCAL CONJUGATE			<input type="checkbox"/> MENINGOCOCCAL		
<input type="checkbox"/> HEPATITIS A			<input type="checkbox"/> HUMAN PAPILLOMAVIRUS		
<input type="checkbox"/> OTHER			<input type="checkbox"/> OTHER		
SIGNATURE OF NURSE:			DATE:		
NOTES:					

SIGNATURE OF PARENT OR LEGAL GUARDIAN X	PRINT PARENT OR GUARDIAN'S NAME	RELATIONSHIP TO CHILD	DATE
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Name/Nombre	Birth Date/Fecha de nacimiento
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QUESTIONS FOR PERSON RECEIVING IMMUNIZATIONS			PREGUNTAS PARA LA PERSONA QUE RECIBIRÁ LAS VACUNAS		
1. Do you have fever, vomiting or diarrhea today?	<input type="checkbox"/> Yes <input type="checkbox"/> No		1. ¿Hoy tiene fiebre, vómitos o diarrea?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
2. Do you have something more than a cold?	<input type="checkbox"/> Yes <input type="checkbox"/> No		2. ¿Está enfermo y es algo más que un resfriado?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
3. Are you taking medicine? If yes, what?	<input type="checkbox"/> Yes <input type="checkbox"/> No		3. ¿Está tomando algún medicamento? Si la respuesta es afirmativa, ¿cuál medicamento está tomando?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
4. Do you have allergies to any medication, food or vaccine? <input type="checkbox"/> Eggs <input type="checkbox"/> Gelatin <input type="checkbox"/> Neomycin <input type="checkbox"/> Latex <input type="checkbox"/> Steptomycin <input type="checkbox"/> Bakers Yeast <input type="checkbox"/> Thimerosal	<input type="checkbox"/> Yes <input type="checkbox"/> No		4. ¿Es alérgico a algún medicamento, comida o vacuna? <input type="checkbox"/> huevos <input type="checkbox"/> gelatina <input type="checkbox"/> neomicina <input type="checkbox"/> látex <input type="checkbox"/> estreptomycin <input type="checkbox"/> levadura de panadería <input type="checkbox"/> timerosal	<input type="checkbox"/> Sí <input type="checkbox"/> No	
5. Have you had a serious reaction to a vaccine in the past? If yes, what kind of reaction?	<input type="checkbox"/> Yes <input type="checkbox"/> No		5. ¿Ha tenido anteriormente reacciones adversas a una vacuna? Si la respuesta es afirmativa, ¿en qué consistió esta reacción?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
6. Have you had any shots within the last three months? If yes, what shot?	<input type="checkbox"/> Yes <input type="checkbox"/> No		6. ¿Se le ha administrado alguna vacuna en los últimos tres meses? Si la respuesta es afirmativa, ¿cuál vacuna se le administró?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
7. Do you have or do you come in contact with anyone who has: <input type="checkbox"/> Cancer <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Leukemia <input type="checkbox"/> Large doses of steroids <input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No		7. ¿Tiene o ha entrado en contacto directo con alguien que tiene alguna de las siguientes enfermedades o recibe los siguientes tratamientos? <input type="checkbox"/> cáncer <input type="checkbox"/> quimioterapia <input type="checkbox"/> leucemia <input type="checkbox"/> grandes dosis de esteroides <input type="checkbox"/> vih/sida	<input type="checkbox"/> Sí <input type="checkbox"/> No	
8. Have you received blood, a blood product or immune(gamma) globulin in the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No		8. ¿Ha recibido transfusiones de sangre, algún producto derivado de sangre o globulina inmune (gamma) en los últimos 12 meses?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
9. Have you had a seizure, brain or nerve problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No		9. ¿Ha tenido convulsiones o algún problema neurológico?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
10. Have you had the disease Hepatitis A?	<input type="checkbox"/> Yes <input type="checkbox"/> No		10. ¿Ha padecido de Hepatitis A?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
11. Have you had the chickenpox? If yes, at what age?	<input type="checkbox"/> Yes <input type="checkbox"/> No		11. ¿Ha padecido de varicela? Si la respuesta es afirmativa, ¿a qué edad?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
12. Have you had the varicella (Chickenpox) vaccination?	<input type="checkbox"/> Yes <input type="checkbox"/> No		12. ¿Se le administró la vacuna contra la varicela?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
13. Have you ever experienced Guillain-Barre Syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No		13. ¿Ha padecido del Síndrome de Guillain-Barré?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
14. For Females 10 years of age and older: are you pregnant or planning a pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No		14. Mujeres mayores de 10 años: ¿Está embarazada o está planeando quedar embarazada?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
15. Where did you hear about this clinic? (Check One) <input type="checkbox"/> TV <input type="checkbox"/> Radio <input type="checkbox"/> Newspaper <input type="checkbox"/> School Flier <input type="checkbox"/> Family or Friend <input type="checkbox"/> Other _____			15. ¿Cómo supo de esta clínica? (Marque uno) <input type="checkbox"/> TV <input type="checkbox"/> radio <input type="checkbox"/> periódico <input type="checkbox"/> escuela <input type="checkbox"/> familiar o amigo <input type="checkbox"/> otro _____		

SIGNATURE OF PARENT OR LEGAL GUARDIAN / FIRMA DEL PADRE, MADRE O TUTOR X	PRINT PARENT OR GUARDIAN'S NAME / NOMBRE DEL PADRE, MADRE O TUTOR	RELATIONSHIP TO CHILD / PARENTESCO CON EL MENOR	DATE / FECHA
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