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** ( )	☐ Cell ☐ Home
ADDRESS	**CITY**	**STATE**	**ZIP**
SEX AT BIRTH ☐ Female ☐ Male	**GENDER IDENTITY** (*optional*) ☐ Female ☐ Male ☐Non-binary ☐ Unknown ☐ Prefer not to say	**Ethnicity:** ☐ Hispanic/Latino ☐ Unknown ☐ Not Hispanic/Latino	
RACE ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other			

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: ☐ Father ☐ Mother ☐ Legal 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.

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 (heretoafter "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:__________________

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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 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: ______________________________			
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 or take a blood thinner?			
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, DiGeorge syndrome or Wiskott-Aldrich syndrome)			
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:
☐ 0-Not Eligible ☐ 1-Medicaid ☐ 2-Native American ☐ 3-Native Alaskan ☐ 4-Underinsured ☐ 5-No Insurance ☐ 6-Private Insurance

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: _______________
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: _________________

Provider Signature: