



Oklahoma State Department of Health/Chickasaw Nation
Influenza Vaccination Partnership



Last Name: _____		First Name: _____	MI: _____	Date of Service: _____
Date of Birth: _____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race (circle all that applies) 1 - Black 2 - Hispanic 3 - Asian/Pacific Islander 4 - American Indian/Alaskan Native 5 - White	
Month Day Year				
Mothers Maiden Name: _____				
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:				
		YES	NO	
1. Is the person to be vaccinated sick today?		<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?		<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?		<input type="checkbox"/>	<input type="checkbox"/>	
4. Has the person to be vaccinated ever had Guillain-Barré Syndrome within 6 weeks after receiving a flu vaccine?		<input type="checkbox"/>	<input type="checkbox"/>	
5. I understand if my child is not cooperative, the vaccine will not be administered.		<input type="checkbox"/>	<input type="checkbox"/>	
6. My child may receive this vaccine without my presence.		<input type="checkbox"/>	<input type="checkbox"/>	
<p>I have read or had explained to me the information contained in the 2019-2020 Vaccine Information Sheet for the 2019 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.</p>				
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				