Oklahoma's Caring Vans

TULSA HEALTH Department

OKLAHOMA CARING VAN PROGRAM/TULSA COUNTY HEALTH DEPARTMENT (THD)
COVID-19 VACCINE CONSENT/AUTHORIZATION FORM

IN ORDER FOR THIS CONSENT/AUTHORIZATION TO BE VALID, IT MUST BE COMPLETED IN ITS ENTIRETY AND SIGNED BY A PARENT OR GUARDIAN. PLEASE USE ONLY BLACK OR BLUE INK TO COMPLETE THIS FORM. ONLY FILL OUT AND RETURN IF YOU WANT YOUR CHILD TO HAVE A COVID-19 VACCINE.

IS THIS THE PATIENT'S — ☐ 1ST DOSE ☐ 2ND DOSE ☐ 3RD DOSE — OF THE COVID-19 VACCINATION?

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH (MM/DD/YYYY)	AGE	GENDER: ☐ FEMALE ☐ MALE

STREET ADDRESS	CITY	STATE	ZIP

PHONE NUMBER ☐ CELL ☐ HOME	LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER_____	ETHNICITY: HISPANIC ORIGIN? ☐ YES ☐ NO	RACE: ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐ WHITE

PATIENT INSURANCE INFORMATION

☐ MY CHILD HAS COVERAGE THROUGH SOONERCARE/MEDICAID
☐ MY CHILD IS AMERICAN INDIAN OR NATIVE ALASKAN ☐ MY CHILD IS UNINSURED

☐ MY CHILD HAS PRIVATE INSURANCE (ENTER INFORMATION BELOW)

PROVIDER NUMBER	GROUP NUMBER	POLICY HOLDER

PLEASE CHECK ONE OF THE FOLLOWING BOXES:
MY CHILD'S IMMUNIZATIONS CAN BE DONE
☐ **WITHOUT MY PRESENCE**.
☐ **WITH MY PRESENCE**.

MEDICAL SCREENING QUESTIONS FOR PATIENT RECEIVING COVID-19 IMMUNIZATION

1. DO YOU HAVE A FEVER (>100F), INFECTION OR CURRENT ILLNESS TODAY? ☐ YES ☐ NO
2. DO YOU HAVE AN ALLERGY TO A PREVIOUS DOSE OF COVID VACCINE OR A COMPONENT OF THE COVID VACCINE? ☐ YES ☐ NO
3. HAVE YOU HAD A SEVERE ALLERGIC REACTION (ANAPHYLACTIC) TO SOMETHING ELSE (FOOD, PET, INSECT BITE, ETC.) ☐ YES ☐ NO
4. HAVE YOU RECEIVED PASSIVE ANTIBODY THERAPY AS TREATMENT FOR COVID-19? ☐ YES ☐ NO
5. HAVE YOU EVER HAD A SIGNIFICANT ALLERGIC REACTION TO ANOTHER VACCINE OR OTHER INJECTION? ☐ YES ☐ NO
6. ARE YOU PREGNANT, PLAN TO BE PREGNANT OR CURRENTLY BREASTFEEDING? ☐ YES ☐ NO
7. DO YOU HAVE A BLEEDING DISORDER OR ARE YOU TAKING A BLOOD THINNER? ☐ YES ☐ NO
8. DO YOU HAVE A SEVERELY IMMUNOCOMPROMISING CONDITION? ☐ YES ☐ NO
9. HAVE YOU RECEIVED ANOTHER VACCINE IN THE LAST 14 DAYS? ☐ YES ☐ NO
10. DO YOU HAVE DERMAL FILLERS? ☐ YES ☐ NO

THIS CONSENT SHALL REMAIN IN EFFECT FOR 90 DAYS AFTER THE DATE SIGNED Consent: I, the undersigned, give my consent for the services that I am requesting from the Tulsa Health Department (THD) with assistance from the Oklahoma Caring Vans Program I acknowledge that I received the vaccine manufacturer Fact Sheet for Recipients and Caregivers prior to receiving the vaccine and have had the opportunity to ask questions. I understand the benefits and risks of the vaccine and request it be administered to me or the person for whom I am authorized to make consent. I, the undersigned, do hereby authorize the Tulsa 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 have reviewed the Notice of Health Information Practices (HIPAA) and understand the information may be provided to public health officials, health care professionals and insurance processing entities. 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 Tulsa 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 from patients.

SIGNATURE	RELATIONSHIP TO PATIENT	DATE

FOR MINORS ONLY — PARENT/GUARDIAN SIGNATURE	FOR MINORS ONLY — PATIENT/GUARDIAN PRINT NAME	DATE

FOR CLINIC USE ONLY — DO NOT WRITE BELOW THIS LINE

DATE ADMINISTERED	VACCINE TYPE	MANUFACTURER	LOT NUMBER/ EXP DATE	SITE		OSIIS DATA ENTRY COMPLETE	IPAD PORTAL COMPLETE
	COVID-19 VACCINE						

NURSE / VACCINE ADMINISTRATOR — PRINT NAME	SIGNATURE

For Vaccine Information Sheets, please visit https://www.cdc.gov/vaccines/hcp/vis/index.html