Department of Health
1921 Stonecipher Boulevard / Ada, OK 74820 / (580)436-3980 / Fax (580) 421-4512

Patient Identification

Influenza Immunization Consent
for Public Health Nursing

Date: _____

Name: _____
First   Middle   Last   Suffix

Birth date: _____   Gender: ☐ Male   ☐ Female   CNDH chart no.: _____   Employee ID no.: _____

Race: (check all that apply)
☐ Black   ☐ Hispanic   ☐ Asian/Pacific Islander   ☐ American Indian/Alaskan Native   ☐ White

Address: _____
Street   City   State   ZIP

Phone no.: (_____) _____   Mother's maiden name: _____

Parent/legal guardian name (for children only): _____
First   Middle   Last   Suffix

Emergency contact name: _____   Phone no.: (_____) _____

Please check one:
☐ Private Insurance (policy/group no. including letter): _____   ☐ Medicaid no.: _____
☐ Medicare (no. including letter): _____   ☐ No insurance

1. Is the person to be vaccinated sick today?   ☐ Yes   ☐ No

2. Has the person to be vaccinated ever had a serious reaction to the influenza vaccine or eggs in the past?   ☐ Yes   ☐ No

3. Has the person to be vaccinated ever had Guillain-Barré Syndrome within 6 weeks after receiving the flu vaccine?   ☐ Yes   ☐ No

4. I understand if my child is not cooperative, the vaccine will not be administered.   ☐ Yes   ☐ No

5. My child may receive this vaccine without my presence.   ☐ Yes   ☐ No

I have read and had explained to me the information contained in the 2022-2023 Vaccine Information Sheet for the 2022 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).

_____   _____
Patient signature   Date/time

_____   _____
Parent/legal guardian signature (if child)   Date/time

For Office Use Only:
Vaccine: _____   Lot no.: _____   Exp.date: _____

Site given: ☐ RVL   ☐ LVL   ☐ RD   ☐ LD

_____   _____   _____
Nurse (print name)   Nurse signature   Date/time