PASSPORT HEALTH®

School Immunization Program Consent Form

Patient Name: _____ **Date of Birth:** _____ **Age:** _____
(First) (M I) (Last) (Suffix)

☐ Male ☐ Female **Race*:** _____ **Mother's Maiden Name*:** _____

Address: _____
(Street) (City) (State) (Zip)

Parent/Guardian Name: _____ **Parent Date of Birth:** _____

Parent Cell/Home Phone: _____

** The answers to these questions are required in order to enter your child's immunization(s) into the state immunization registry.*

Insurance Information (you may attach a copy of ID card or complete below)

Carrier Name: _____ **ID #:** _____ **Group #:** _____
(ex: SoonerCare, BCBS, United) *(Some ID cards do not have a Group #)*

Is the child listed as the primary insured? **If no, please list Name and Date of Birth of primary:**

Name: _____ **Date of Birth:** _____

Immunization Preferences

☐ **Please update my child on any age-recommended immunizations available.**

☐ **Please provide only the following immunizations to my child (please list):**

I consent and authorize my child to receive immunization(s) from Passport Health Oklahoma without my physical presence and based on my selection above. I am a legal parent/guardian to the above-named student. I understand that Passport Health Oklahoma maintains the right to decline any immunization to my child if he/she is unruly and presents a risk for unintentional needle-stick to staff or himself/herself. I have had a chance to read regarding the immunization(s) offered and any questions have been answered. I have had a chance to read and ask questions in advance related to benefits/risks of the vaccines offered. I authorize the child's immunization record to be released for public health and state law purposes to include OK State Health Department, school & district, and pediatrician.

Signature of Parent/Guardian: _____ **Date:** _____

OFFICE USE ONLY:
Insurance: _____ Date: _____
OSIIS: _____ Date: _____
PW: _____ Date: _____

Please continue to Page 2 (on the back) ▶

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Screening Questions

		Yes	No	Don't Know
1.	Does your child have a high fever? **If YES, please explain:**	☐	☐	☐
2.	Does the child have an allergy to eggs? Allergy to any other medication, vaccine component, or latex? **If YES, please list:**	☐	☐	☐
3.	Has the child ever had a serious reaction after receiving a vaccination? **If YES, please explain:**	☐	☐	☐
4.	Does the child have asthma? **If YES,** does the child use any inhalers or other breather treatment?	☐ ☐	☐ ☐	☐ ☐
5.	Does the child have a weak immune system? Such as a history of cancer, leukemia, AIDS, or any other immune system problem? **If YES, please list:**	☐	☐	☐
6.	In the past 3 months, has the child taken aspirin daily, cortisone, prednisone, other steroids, or anticancer drugs, or any radiation therapy? **If YES, please list:**	☐	☐	☐
7.	Has the child had a seizure or brain or other nervous system problem including Guillain-Barré Syndrome? **If YES, please explain:**	☐	☐	☐
8.	Does the child have any long-term health conditions such as heart or lung disease, seizure disorder, cerebral palsy, muscle/nerve disorder, diabetes, or sickle cell disease? **If YES, please explain:**	☐	☐	☐
9.	During the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? **If YES, please list:**	☐	☐	☐
10.	Has the child received any vaccinations in the past 4 weeks? **If YES, please list:**	☐	☐	☐
11.	**For young women**: Is there a possibility that the child is pregnant?	☐	☐	☐

Please return consent form to school. Please direct any questions regarding this form, the immunizations offered, or insurance eligibility to Passport Health Oklahoma at one of the numbers below.

Oklahoma City: (405) 563-8961 **Tulsa: (918) 770-4290**

Office Use Only

Vaccine:_____ **Site:**_____ **Lot #:** _____ **Exp:** _____

Vaccine:_____ **Site:**_____ **Lot #:** _____ **Exp:** _____

Vaccine:_____ **Site:**_____ **Lot #:** _____ **Exp:** _____

Vaccine:_____ **Site:**_____ **Lot #:** _____ **Exp:** _____

Additional Nurse Notes: