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Immunization Parental Consent Form

Location/School Name ___________________________

All questions must be filled out and both pages must be signed and returned to your child's school in order to participate.

Students Last Name	Students First Name	Students Middle int.	Suffix	Date of Birth	Age	Gender
						Gender

Birth Country	Birth State	Language (circle one)	Mothers Maiden Name
		English, Spanish, ASL, Other	
Ethnicity (circle one Below)		Adopted Child? Yes or No	Foster Child Yes or No

American Indian Alaskan Native Asian African American White Hispanic Native Hawaiian Pacific Islander Other

Street Number and Name	City	State	Zip Code	County

Parent/Guardian Name:	
Is your child listed as a dependent on Insurance?	**Yes - No**
Name of Primary Insurance Member:	
Birthdate of Primary Insured:	
Parent Cell or Home Phone Number:	
Insurance information below	Students with HMP Coverage must see an APPROVED Provider on their own HMO List This services is unfortunately not available
Group #	**SoonerCare**
ID Number:	**ID Number:**

Below are the immunizations offered. ***Please indicate YES or NO on each shot listed. If unsure what is required for your child, please simply circle NO on any vaccinations you refuse or do not want your child to receive.*** **We will determine what your child needs and is recommended to have by the State of Oklahoma and the Center for Disease Control (CDC) and then give appropriately.**

Flu	Yes	No	Tdap	Yes	No	Meningococcal	Yes	No	HPV	Yes	No

I consent and authorize my child to receive immunization(s) from Total Wellness without my physical presence. I am the legal parent/guardian to the above named student. I understand that Total Wellness maintains the right to decline any immunization, to the child listed above, if he/she presents a risk of unintentional needle stick to staff or himself/herself. I have had a chance to read and ask questions in advance related to the benefits and the risk(s) of the vaccinations offered and acknowledge understanding. Please visit the CDC for the Vaccine Information Sheets on all vaccines offered at https://www.cdc.gov/vaccines/hcp/vis/current-vis.html. I hereby authorize the child listed above to have any and all immunizations the State of Oklahoma requires for entry into school and to receive the optional vaccines I have indicated by circling YES above. Total Wellness will release these records to the Oklahoma State Immunization Information System.

Parent/Guardian Signature ______________________________ Date_____/_____/ ______

FOR OFFICE USE ONLY: Place sticker and lot # here

TW Staff Signature______________________Date______/______/ ______

Back of Form

Immunization Parental Consent Form

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If your child has a temperature of 100.4 degrees or higher within 24 hours of the scheduled immunizations event, they are not eligible to participate. Please inform the office. Temp in ○________TW Staff Initials ________

Students Name: ______________________	Birth Date: ______________		
Does your child have asthma?	Yes	No	Unsure
If yes, does this child use any inhalers or other breathing treatments?			
In the past 3 months, has your child taken aspirin daily, cortisone, prednisone, other steroids, anticancer drugs, or any radiation therapy?	Yes	No	Unsure
If yes, please list :			
During the past year has your child received a blood transfusion, blood products, or been given immune (gamma) globulin or an antiviral drug?	Yes	No	Unsure
If yes, please list:			
Has your child received any vaccinations in the past 4 weeks?	Yes	No	Unsure
If yes, please list:			
Does your child have any long term health conditions such as: heart or lung disease, seizure disorder, cerebral palsy, muscle or nerve disorder, diabetes, or sickle cell disease?	Yes	No	Unsure
If yes, please list:			
Has your child had a seizure or other nervous system problems including Gullain-Barre Syndrome?	Yes	No	Unsure
If yes, please list:			
Does your child have a weakened immune system? Any history of cancer, leukemia, AIDS, Chron's diease, or any other immune system concerns?	Yes	No	Unsure
If yes, please list:			
Does your child have any allergy to eggs? Allergy to any medications or vaccinations component?	Yes	No	Unsure
If yes, please list:			
For Young Women Only			
Is there any chance your child is pregnant?	Yes	No	Unsure
Has your child ever had a serious reaction after having a vaccination?	Yes	No	Unsure
If yes, please explain			

Parent/Guardian Signature ______________________ Date______/______/______

Please call us with any questions at 405-658-3130 or visit our website at http://totalwellnessok.com

TW Staff Signature______________________Date______/______/ ______