Total Wellness Corporate Health

2022 Parental Consent for Immunizations

Be sure Parent circled "YES" before giving shot.

Laboratory Address: 7017 N. Robinson, Oklahoma City OK 73116 CLIA #37D2120685

School Name/Location_______________________________________

Teacher Name/Grade____

Please complete all information to the yellow line and bring to reception desk **Date** ____/____/_______

Student Name (Legal)			
Student Date of Birth: ____/____/____________	**Student Gender**	☐ **Male**	☐ **Female**
Home Address			
City	**State**	**Oklahoma**	
Zip Code	**Parent/Guardian Cell Phone:**		

PLEASE PROVIDE INSURANCE INFORMATION: For Soonercare ID Number: Please call Member Services at 800-987-7767

Insurance Provider	Member ID Number	Group/ Policy Number	Primary Insured Date of Birth
			_____/_____/____________

	Race (please check one)				Ethnicity (please check one):
☐	American Indian/Alaska Native	☐	White	☐	Hispanic or Latino
☐	Asian	☐	Other Race	☐	Not Hispanic or Latino
☐	Black or African American	☐	Patient Declines	☐	Unknown
☐	Native Hawaiian or Other Pacific Islander			☐	Patient Declines

Please circle Yes or NO to each of the following questions:

1	Has your child ever had an allergic reaction to a vaccination, eggs, any medication or vaccine component? If yes, please list reaction type	Yes	No
2	Has your child had any vaccinations in the last 8 weeks? If yes, please list which vaccination(s):	Yes	No
3	Does your child have sickle cell disease? If yes, when was their last sickle cell crisis? If yes, have they had a fever or shortness of breath in the last 2 weeks?	Yes	No
4	Does your child have a history of cancer, leukemia, AIDS/HIV, a muscle/nervous system disorder, a seizure disorder, Gullain-Barre syndrome or any other immune sytem, autoimmune disorder or any other chronic or long-term condition?	Yes	No
5	Has you child had aspirin daily, antiviral drugs, anticancer drugs, steroids for cancer, radiation therapy, immune/immune gamma globulin, a blood transfusion or any blood products in the past 8 weeks? If yes, please list:	Yes	No
6	*For Females only* Is there currently a chance she is pregnant?	Yes	No

Listed Below is the immunization offered today. Please circle Yes on the immunization listed for your child.

Tdap (Tetanus/Diptheria & Pertussis). YES **Meningococcal (Meningitis). YES**

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 child. 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 all immunizations the State of Oklahoma requires for entry into school and to receive the optional vaccines I have indicated by circling YES

Parent/Guardian SIGNATURE:_________________________________

Date _______/_______/________________

PLEASE COMPLETE EVERYTHING ABOVE THIS LINE AND RETURN TO REGISTRATION

Private Stock Vaccines: Do NOT Enter Private Stock Vaccines into OSIIS!

Date	Vaccine Type	Manufacturer	Lot Number	Expiration Date	Site

VFC Vaccines: VFC Vaccines MUST be Keyed into OSIIS!

Date	Vaccine Type	Manufacturer	Lot Number	Expiration Date	Site

Vaccine Administrator:____

Print Name:_______________________________ **Date:**__________________

Data Entry
OSIIS Complete
Initial__________