# Cherokee Nation Health Services
# Registration and Consent for Community Based Medical Services - MINOR

Please fill out completely

Name: Last _____ First _____ M.I. _____ Other Names Used _____

Sex: M F Date of Birth _____ Tribe of Membership _____ Tribal Number _____

Social Security Number _____ Mother's Maiden Name _____ Father's Name _____

Home Phone: _____ Alternate Phone: _____

Currently Mailing Address: _____

City: _____ State: _____ Zip: _____

If child is not Indian, is child living in home with step parent, foster parent, adoptive parent, or guardian who is Indian? Y N

Parent/Guardian Phone # During School Hours _____ Medicaid/SoonerCare # _____

Medical Insurance Company _____ Policy # _____

Effective/Beginning Date of Policy: _____ Name of Person Carrying Insurance Policy _____

Address of Insurance Company _____ Relationship to Child _____

**Patient Portal Registration**: All Patients may have access to their medical records online through the Patient Portal. Patients Age 0-12 require use of parents' email address. Patients Age 13-17 may sign-up for the Patient Portal using minor's own email address. For Age 13-17: Patient Portal Proxy Form must be completed if granting Parent/Guardianship Access.

Patient Portal Preferred Email Address: _____

_____

**Consent for Non-Invasive Preventive Services**

I am the parent or legal guardian of _____. I give my permission for my child to have non-invasive procedures such as vision screenings, dental screenings, hearing screenings and head lice checks given by Cherokee Nation Health Services.

Parent/Guardian Signature: _____ Date _____

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**Consent for Immunizations/Laboratory Testing**

I am the parent or legal guardian of _____. I give my permission for my child to have the following immunizations and/or laboratory testing performed by Cherokee Nation Health Services.

| | | | |
|---|---|---|---|
| Hepatitis A_____ | | Hepatitis B_____ | HiB _____ |
| DTaP (Diphtheria, Tetanus & Whooping Cough) _____ | | Varicella (Chickenpox) _____ | IPV (Polio) _____ |
| MMR (Measles, Mumps, Rubella) _____ | | Pneumococcal_____ | Tdap/Td_____ |
| Meningitis_____ | | Rotavirus_____ | HPV_____ |
| Influenza_____ | Finger stick_____ | COVID-19 _____ | Other_____ |

**Please select all that apply:**

_____ My child's _____immunization and/or _____ laboratory testing can be done **WITHOUT MY PRESENCE.**

_____ My child's _____immunization and/or _____laboratory testing can **ONLY** be done **WITH MY PRESENCE.**

Parent/Guardian Signature: _____ Date _____ Time _____

# Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

PATIENT NAME _____

DATE OF BIRTH ____ / ____ / ____
month day year

**For patients (both children and adults) to be vaccinated:** The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

| | yes | no | don't know |
|---|---|---|---|
| **1.** Is the person to be vaccinated sick today? | ☐ | ☐ | ☐ |
| **2.** Does the person to be vaccinated have an allergy to a component of the vaccine? | ☐ | ☐ | ☐ |
| **3.** Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? | ☐ | ☐ | ☐ |
| **4.** Has the person to be vaccinated ever had Guillain-Barré syndrome? | ☐ | ☐ | ☐ |

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

immunization action coalition
immunize.org

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4066.pdf • Item #P4066 (9/20)