Dear Parent/Guardian,

In partnership with your child's school district, nurses from Passport Health Oklahoma will offer immunizations on-site, at school. Passport Health Oklahoma is an immunization specific clinic and partners with many school districts, state agencies, and private businesses to improve access to immunizations.

Children eligible for the Vaccines for Children (VFC) program and children covered by other health insurance plans are invited to participate. A valid SoonerCare/Medicaid or other health insurance card is required if your child is insured.

If your child is uninsured, he/she is also invited to participate and is eligible for the VFC program.

You may attach a copy of the insurance card with the consent form, or you may note the insurance *ID number* and *Group number* on the form.

A consent form must be completed for each participating child; participation is optional.

Please select from the following options:

( ) My child is eligible for the VFC program:

□ My child is enrolled with SoonerCare/Medicaid.
□ My child is uninsured.
□ My child is Native American, Native Alaskan, Hawaiian, or Pacific Islander.

( ) My child has coverage with one of the following health insurance plans:

□Aetna	□ BlueCross BlueShield	□Cigna
□Coventry	□ First Health	□ GEHA
□ GlobalHealth	□ HealthChoice	□ Humana
□ Mutual Assurance	□ Tricare	□ United

Mark the vaccinations in which you would like your child to receive:

□ Tdap (required to enroll in 7th grade)
□ Meningitis
□ HPV

Please call Passport Health at 405-563-8961 for any questions regarding insurance eligibility or related to the consent form. You may call between 9am and 5pm Monday- Friday.

CONSENT FORM – THIS PAGE IS REQUIRED

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) ▶

PASSPORT HEALTH®

School Immunization Program Consent Form

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: