



Bryan County Health Department

1524 W. Chuckwa Street
Durant, Oklahoma 74701
O: 580-924-4285
F: 580-924-1651

09/16/2021

Dear Parent/Guardian:

No Cost Influenza/COVID 19 Vaccine!!!!

As part of a continued collaboration between the Health Department and the Choctaw Nation of Oklahoma, a school flu vaccination program is available this year which will provide voluntary flu vaccinations. This year we will also be offering voluntary COVID 19 vaccine for ages 12 and up. Both vaccines are available at **no charge to school staff and students (native and non-native)**. Second doses of COVID 19 vaccine can be obtained by calling your local Health Department. This program would not be possible without the support of the Choctaw Nation of Oklahoma.

Health Department/Choctaw Nation nurses will be at your school on Wednesday, 10/06/2021. Attached you will find consent forms that must be completed and returned by Friday, 10/01/2021 in order for your child to receive a vaccine. We will be unable to immunize anyone under 18 years old without completed consent forms. Please go to the following links for vaccine information:

[Inactivated Influenza Vaccine Information Statement | CDC](https://www.cdc.gov/vaccines/covid-19/eua/pfizer.html)
<https://www.cdc.gov/vaccines/covid-19/eua/pfizer.html>

Only injectable vaccines will be provided. If students are not cooperative, the vaccine will not be administered.

If you have any questions, please contact the Bryan County Health Department at 580-924-4285.

Sincerely,



Amy Potts Rn

Bryan County Health Department

CONSENT FORMS BELOW



**Oklahoma State Department of Health/Choctaw Nation
Influenza Vaccination Partnership
Consent Form for Influenza Vaccine**



Name (First, MI, Last Name)		Date of Birth	Age	Grade	Race (Circle One)	Gender
					Black Hispanic Asian/Pacific Islander White American Indian/Alaskan Native	
Address		City	Zip	Phone #		Birth State

Mother's Maiden Name: (This is used to help identify you in the Oklahoma State Immunization Registry)

Please circle what applies. *Everyone qualifies for this flu vaccine*

SoonerCare
 Native American
 No Insurance
 Private Insurance
 Pacific Islander

1. Is the person to be vaccinated sick today?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to a component of the vaccine	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Has the person ever had Guillain-Barré Syndrome?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

I have read and had explained to me the information contained in the Influenza Vaccination Information Sheet (8/15/19). I have had the opportunity to ask questions which have been answered to my satisfaction. I understand the risks and benefits of the Influenza Vaccine. I give my consent for Oklahoma State Department of Health/Choctaw Nation Nurses to administer Influenza Vaccine to myself or my child (if applicable). Information regarding immunization can be released to health care providers, public health officials, school and the Oklahoma State Department of Health. I understand this vaccination will be recorded in the Oklahoma State Immunization Information System. I agree for my child to receive this vaccine without my presence and understand if my child is not cooperative the vaccine will not be administered.

Signature	Date

Relationship to client: Self or Parent/Guardian

For Administrative Use Only - DO NOT WRITE BELOW

Vaccine	Vaccine Manufacturer	Lot Number	Route	Location	Name and Title of Vaccine Administrator	Date
AFLURIA	SEQIRUS	P100358553 EXP 6-22	0.5mL Intramuscular	RD LD RVL LVL		

This consent shall remain in effect for 90 days after the date signed.

COVID-19 Vaccine Consent Form (Child/Adolescent)

Please print information about the Child to receive vaccine

CHILD'S NAME (Last)		(First)	(M.I.)	SUFFIX (eg. Jr, III)	
MOTHER'S MAIDEN NAME		DATE OF BIRTH (MM/DD/YYYY)	AGE	PHONE	
ADDRESS			CITY	STATE	ZIP
IS CHILD A TWIN, TRIPLET, ETC? <input type="checkbox"/> Yes <input type="checkbox"/> No		BIRTH STATE		SOCIAL SECURITY NUMBER	
Race <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other			HISPANIC ORIGIN? <input type="checkbox"/> Yes <input type="checkbox"/> No		GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male

Screening for Vaccine Eligibility	YES	NO
Has your child ever received a dose of the COVID-19 vaccine? If yes, which vaccine did s/he receive? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson and Johnson) <input type="checkbox"/> Other _____		
Has your child ever had an allergic reaction to: <input type="checkbox"/> a component of a COVID-19 vaccine, including either of the following: -polyethylene glycol (PEG), which is found in some medications, such as laxatives and preps for colonoscopy procedures -polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids <input type="checkbox"/> a previous dose of COVID-19 vaccine <input type="checkbox"/> a vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 component, but it is not known which component elicited the immediate reaction		
Has your child ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?		
Has your child ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.		

CONSENT FOR CHILD'S VACCINATION AND RELEASE OF VACCINATION INFORMATION:

I have read or had explained to me the information contained in the *Emergency Use Authorization Fact Sheet for Recipients and Caregivers* for the COVID-19 vaccine and understand the risks and benefits of the vaccine. I have had a chance to ask questions which have been answered to my satisfaction. I understand the benefits and risks of the vaccine. I understand that if my child exhibits disruptive behavior while staff is trying to administer the vaccine they will not receive the vaccine at this clinic and will have to be taken to the health department or to their provider for this vaccine.

I authorize disclosure of this vaccination information to public health officials and other health care professionals. I understand that this vaccination will be recorded in the Oklahoma State Immunization Information System (OSIIS) for the purposes of sharing vaccination information with other health care providers and tracking vaccine inventory only.

“In the event of an emergency situation, emergency medication (Epinephrine/Benadryl) and/or oxygen may be administered to my child.”

Signature of Parent/Guardian _____ Date: _____

Please print Parent/Guardian name _____

OFFICE USE ONLY

Ask before administration:

Is the client suffering from a moderate or severe acute illness with or without fever?

Is the client pregnant?

VACCINE INFO: Administered by: _____ Date: _____

COVID-19 Pfizer__ Moderna__ Janssen__ Other__ Lot #: _____ Exp Date: _____

Site: R or L arm Funding Source: VFC State Local