OKLAHOMA State Department of Health

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 Monday, 10/04/*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

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 vaccinate sick today?	Yes ☐	No ☐
2. Does the person to be vaccinated have an allergy to a component of the vaccine	Yes ☐	No ☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	Yes ☐	No ☐
4. Has the person ever had Guillain-Barré Syndrome?	Yes ☐	No ☐

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? ☐ Yes ☐ No	**BIRTH STATE**	**SOCIAL SECURITY NUMBER**

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other	**HISPANIC ORIGIN?** ☐ Yes ☐ No	**GENDER** ☐ Female ☐ 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? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson and Johnson) ☐ Other _____		
Has your child ever had an allergic reaction to: ☐ 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 ☐ a previous dose of COVID-19 vaccine ☐ 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**