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 ☐
5. Has the person to be vaccinated ever felt dizzy or faint before, during or after a shot?	Yes ☐	No ☐
6. Is the person to be vaccinated anxious about getting a shot today?	Yes ☐	No ☐

I have read and had explained to me the information contained in the Influenza Vaccination Information Sheet (01-31-25). 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. In the event of an emergency, emergency medications and/or oxygen may be administered to my child.

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	AX5588A	0.5mL Intramuscular	RD LD RVL LVL		

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