TULSA HEALTH Department

# Immunization Worksheet

| Last Name (Please Print) | First Name | Full Middle Name | Date of Birth | Age | Gender: □ Female □ Male |
|---|---|---|---|---|---|
| | | | | | |

| Street Address | City | County | State | Zip Code |
|---|---|---|---|---|
| | | | | |

| Phone Number □ Cell □ Home | Social Security # *(Optional)* | Ethnicity: Hispanic Origin ☐ Yes ☐ No | Race: □ American Indian/Alaskan Native □ Asian □ White □ Black/African American □ Native Hawaiian/Other Pacific Islander |
|---|---|---|---|
| | | | |

| Language: ☐ English ☐ Spanish ☐Other | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Legally Separated | Birth State: |
|---|---|---|
| | | |

| Do you give permission for us to contact you? ☐ Yes ☐ No | Annual Gross Income *(optional)*: $_____ | How many in household supported by Income: | Email Address: |
|---|---|---|---|
| | | | |

## Required for Minor Children

| Mother's First Name: | Last Name: | Maiden: | Father's Name: |
|---|---|---|---|
| | | | |

## Medical Insurance Information

Does patient have medical health insurance ☐ Yes ☐ No If yes, please provide your insurance information:

| ☐ Medicaid/Soonercare | Medicaid Number: | First and Last name as it appears on card | Mother's Maiden Name: |
|---|---|---|---|
| | | | |

| ☐ Private Insurance | Primary Insurance: | Policy Holder: | Group No.: | Policy ID No.: |
|---|---|---|---|---|
| | | | | |

| ☐ Medicare | Do you have Medicare: **Part B:** ☐ Yes ☐ No **Part D:** ☐ Yes ☐ No | Medicare Number: |
|---|---|---|
| | | |

**Consent:** I, the undersigned, give my consent for the services that I am requesting from the Tulsa Health Department (THD) and its entities/contractors. I acknowledge that I received the Vaccine Information Sheet or vaccine manufacturer Fact Sheet for Recipients and Caregivers prior to receiving the vaccine and have had the opportunity to ask questions. I understand the benefits and risks of the vaccine and request it be administered to me or the person for whom I am authorized to make consent. I have reviewed the Notice of Health Information Practices (HIPAA) and understand the information may be provided to public health officials, health care professionals and insurance processing entities.

I hereby authorize THD to bill my private insurance (if applicable) for services provided and understand that I am responsible for any portion not covered by my policy.

Signature (Patient or Parent/Legal Guardian ) :_____ Date:_____

**Required for Minor Children:** Parent or Legal Guardian Print Name:_____ Relationship to minor:_____

| Vaccine | Lot # | Site | Vaccine | Lot # | Site | Vaccine | Lot # | Site |
|---|---|---|---|---|---|---|---|---|
| Dtap, Dtap-IPV, Dtap/Hep B/IPV | | | Hib, HPV9, IPV | | | Rotavirus, RSV | | |
| Dtap-HIB/IPV, Dtap/IPV/Hib/Hep B | | | MENB, MenQuadfi | | | TD, TdaP | | |
| COVID | | | MMR, MMRV, | | | Varicella | | |
| Flu | | | PCV | | | Other | | |
| Hep A, Hep B, HepA/B | | | PCV20, PCV 23 | | | Other | | |

**Provider Signature**: _____ **Date:**_____ **PHOCIS ID:**_____ **OSIIS ID:**_____

**Comment:**_____ **Date Entry Completed on:**_____ **Clerk Int.:**_____

TULSA HEALTH Department

# Immunizations Screening Checklist for Contraindications to Vaccines

| | | Yes | No | Don't Know |
|---|---|---|---|---|
| 1. | Are you sick today? | | | |
| 2. | Do you have allergies to medications, food, a vaccine component, or latex? | | | |
| 3. | Have you had a serious reaction after receiving a vaccine in the past? | | | |
| 4. | Do you have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy? | | | |
| 5. | In the past 3 months, have you taken medicines that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments | | | |
| 6. | During the last year, have you received blood, a blood product or immune (gamma) globulin or an antiviral drug? | | | |
| 7. | Have you or a parent or sibling had a seizure, brain or nervous system problem? | | | |
| 8. | Do you or your parent or sibling have cancer, leukemia, HIV/AIDS, or any other immune system problem? | | | |
| 9. | Have you received any vaccinations in the past 4 weeks | | | |
| 10. | Have you ever experienced Guillain-Barre Syndrome? | | | |
| 11. | For females 10 years of age an older; are you pregnant or planning a pregnancy in the next month? | | | |

***For COVID-19 vaccine recipients:***

| | | | | |
|---|---|---|---|---|
| 1. | Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine did you receive?<br>____Pfizer-BioNTech ____Moderna ____Janssen ____Novavax _____Another Product<br>How many doses were administered? | | | |
| 2. | Have you received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies? | | | |
| 3. | Have you ever had an allergic reaction to a component of a COVID-19 vaccine or a previous dose of COVID-19 vaccine? | | | |
| 4 | Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)* | | | |
| 5. | Check all that apply to you:<br>____Have a history of myocarditis or pericarditis<br>____Have a history of thrombosis with thrombocytopenia syndrome (TTS)<br>____Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)<br>____Have a history of Guillain-Barre Syndrome (GBS)<br>____Have a history of COVID-19 disease within the past 3 months?<br>____History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombopenia (HIT) | | | |

| | |
|---|---|
| Form completed by: | Date: |
| Form reviewed by: | Date: |

Comments: