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

Please answer for the person receiving the vaccines today.

Name:_____ **Date of Birth:**_____

		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?			
5.	Are you on long-term aspirin or salicylate medication?			
6.	In the past 6 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			
7.	During the last year, have you received blood, a blood product or immune (gamma) globulin or an antiviral drug?			
8.	Have you or a parent or sibling had a seizure, brain or nervous system problem?			
9.	Do you or your parent or sibling have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
10.	For babies: Has the child had intussusception?			
11.	Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-C) after an infection with the virus that causes COVID-19?			
12.	Have you received any vaccinations in the past 4 weeks?			
13.	For females 10 years of age and older: Are you pregnant?			
14.	Have you ever felt dizzy or faint before, during or after a shot?			

Form completed by:	Date:
Form reviewed by:	Date:

Comments: