OKLAHOMA DEPARTMENT OF CORRECTIONS
Vaccine Administration Consent/Waiver Form

I have received the Vaccine Information Sheet (VIS) and/or have had the information explained to me about the following vaccine(s):

❒ **Influenza Vaccine** ❒ **Hepatitis B Vaccine (3 shot series)** ❒ **Hepatitis A Vaccine (2 shot series)**

❒ **Tetanus and Diphtheria Vaccine** ❒ **Pneumococcal Vaccine** ❒ **Other:** _____

Please answer the following questions based on the vaccine(s) indicated above:	**Yes**	**No**
1. Have you previously received this vaccine(s)?		
2. Have you previously had a severe reaction to the vaccine(s) indicated above?		
3. Are you allergic to eggs?		
4. Are you allergic to thimerosal?		
5. Are you allergic to baker's yeast?		
6. Have you ever had Guillain-Barre Syndrome (GBS)		
7. Are you currently taking an antibiotic for infection?		
8. Do you feel ill today?		
9. Females: Are you pregnant?		
10. I hereby certify that the history is true and complete to the best of my knowledge.		

I have received the Vaccine Information Sheet and/or have had the information explained to me about the following vaccine.

❒ **COVID-19 Vaccine Select:** ❒ **1 Dose** ❒ **2 Dose** ❒ **Booster**

Please answer the following questions based on the vaccine(s) indicated above:	**Yes**	**No**
1. Are you feeling sick today?		
2. Have you ever received a dose of Covid-19 vaccine?		
3. If "Yes" which one? ❒ Pfizer ❒ Moderna ❒ J & J ❒ Other: _____		
4. Have you ever had a severe reaction (e.g., anaphylaxis to something? Example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?		
• Was the severe allergic reaction after receiving a Covid-19 vaccine?		
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?		
5. Have you received passive antibody therapy (monoclonal antibodies for convalescent serum) as treatment for Covid-19?		
6. Have you received another vaccine in the last 14 days?		
7. Have you had a positive test for Covid-19 or has a doctor ever told you that you had Covid-19? If 'Yes" When: _____		
8. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?		
9. Do you have a bleeding disorder or are you taking a blood thinner?		
10. Are you pregnant or breastfeeding?		

Indicate below whether you accept or waive the vaccine(s).

❒ **CONSENT FOR:** ❒ **Influenza Vaccine** ❒ **Pneumococcal Vaccine** ❒ **Hepatitis B Vaccine (3 shot series)**
❒ **Hepatitis A Vaccine (2 shot series)** ❒ **Tetanus and Diphtheria Vaccine** ❒ **Covid-19** ❒ **Other:** _____

I have had a chance to ask questions that were answered to my satisfaction about the disease the vaccine prevents, the vaccine, and how the vaccine is to be given. I understand the benefits and risks of the vaccine(s) and authorize the healthcare worker to administer the vaccine(s).

_____ _____
Signature of the person to receive the vaccine(s) Date

❒ **WAIVE FOR:** ❒ **Influenza Vaccine** ❒ **Pneumococcal Vaccine** ❒ **Hepatitis B Vaccine (_____ shot series)**
❒ **Hepatitis A Vaccine (____ shot series)** ❒ **Tetanus and Diphtheria Vaccine** ❒ **Covid-19** ❒ **Other:** _____

I have had a chance to ask questions that were answered to my satisfaction about the disease the vaccine prevents, the vaccine, and how the vaccine is to be given. I understand the benefits and risks of the vaccine(s) and waive the vaccine(s) at this time. I understand I may retract my decision and receive the vaccine at a later date, although consequences due to the delay may result.

_____ _____
Signature of the person to receive the vaccine(s) Date

_____ _____
Health Care Provider/RN/LPN Date

Inmate Name: DOC Number/SSN:
(Last, First)