Dear 6th Grade Parents,

Ada City Schools is pleased to announce that we will be providing an onsite Tdap and Meningitis Clinic on May 10th 2022 at the following location:

Willard Elementary School
817 East 9th Street
Ada, OK 74820
May 10th, 2022
8:30am-2:00pm

By providing this at the end of 6th grade school year, it helps students and parents to have one less thing to take care of before enrolling in the 7th grade.

The Oklahoma State Board of Health requires all 7th grade through 12th grade students to show proof of having received one dose of Tdap (tetanus, diphtheria, and pertussis) vaccine before attendance will be allowed. To meet this requirement, an immunization record must be provided to the school showing the date your student received the vaccine. If your student has already received this dose, he or she will not be required to receive it again. Please bring the completed record to Enrollment Confirmation Day or to the Ada Junior High School office prior to your child beginning their seventh-grade year.

Parents may also request and complete an immunization exemption form for valid medical, religious, or philosophical concerns. Tdap vaccine provides continued protection to students from three diseases: tetanus (lockjaw), diphtheria, and pertussis (whooping cough). Whooping cough has been on the rise in the U.S., especially among pre-teens and teenagers 10 through 19 years of age and children under 5 years of age.

- **Tdap vaccine is covered by most health insurance plans including SoonerCare.**
- **The attached waiver must be completed and signed for vaccination authorization.**

****IMPORTANT** If you *"DO NOT"* want your student to receive a Tdap vaccination, please do not return the attached form/waiver.**

Effective July 1, 2021: for school enrollment a parent or guardian shall provide one of the following: Current, up to date immunization records OR A completed and signed exemption form.

Total Wellness Corporate Health

2022 Parental Consent for Immunizations

Be sure Parent circled "YES" before giving shot.

Laboratory Address: 7017 N. Robinson, Oklahoma City OK 73116 CLIA #37D2120685

School Name/Location_____

Teacher Name/Grade_____

Please complete all information to the yellow line and bring to reception desk **Date** ____/____/_____

Student Name (Legal)	
Student Date of Birth: ____/____/_____ **Student Gender** ☐ **Male** ☐ **Female**	
Home Address	
City	**State Oklahoma**
Zip Code	**Parent/Guardian Cell Phone:**

PLEASE PROVIDE INSURANCE INFORMATION: For Soonercare ID Number: Please call Member Services at 800-987-7767

Insurance Provider	Member ID Number	Group/ Policy Number	Primary Insured Date of Birth
			____/____/_____

Race (please check one)				Ethnicity (please check one):	
☐	American Indian/Alaska Native	☐	White	☐	Hispanic or Latino
☐	Asian	☐	Other Race	☐	Not Hispanic or Latino
☐	Black or African American	☐	Patient Declines	☐	Unknown
☐	Native Hawaiian or Other Pacific Islander			☐	Patient Declines

Please circle Yes or NO to each of the following questions:

1	Has your child ever had an allergic reaction to a vaccination, eggs, any medication or vaccine component? If yes, please list reaction type	Yes	No
2	Has your child had any vaccinations in the last 8 weeks? If yes, please list which vaccination(s):	Yes	No
3	Does your child have sickle cell disease? If yes, when was their last sickle cell crisis? If yes, have they had a fever or shortness of breath in the last 2 weeks?	Yes	No
4	Does your child have a history of cancer, leukemia, AIDS/HIV, a muscle/nervous system disorder, a seizure disorder, Gullain-Barre syndrome or any other immune sytem, autoimmune disorder or any other chronic or long-term condition?	Yes	No
5	Has you child had aspirin daily, antiviral drugs, anticancer drugs, steroids for cancer, radiation therapy, immune/immune gamma globulin, a blood transfusion or any blood products in the past 8 weeks? If yes, please list:	Yes	No
6	*For Females only* Is there currently a chance she is pregnant?	Yes	No

Listed Below is the immunization offered today. Please circle Yes on the immunization listed for your child.

Tdap (Tetanus/Diptheria & Pertussis). YES **Meningococcal (Meningitis). YES**

I consent and authorize my child to receive immunization(s) from Total Wellness without my physical presence. I am the legal parent/guardian to the above-named child. I understand that Total Wellness maintains the right to decline any immunization to the child listed above if he/she presents a risk of unintentional needle stick to staff or himself/herself. I have had a chance to read and ask questions in advance related to the benefits and the risk(s) of the vaccinations offered and acknowledge understanding. Please visit the CDC for the Vaccine Information Sheets on all vaccines offered at https://www.cdc.gov/vaccines/hcp/vis/current-vis.html. I hereby authorize the child listed above to have all immunizations the State of Oklahoma requires for entry into school and to receive the optional vaccines I have indicated by circling YES

Parent/Guardian SIGNATURE:_____

Date _____/_____/_____

PLEASE COMPLETE EVERYTHING ABOVE THIS LINE AND RETURN TO REGISTRATION

Private Stock Vaccines: Do NOT Enter Private Stock Vaccines into OSIIS!

Date	Vaccine Type	Manufacturer	Lot Number	Expiration Date	Site

VFC Vaccines: VFC Vaccines MUST be Keyed into OSIIS!

Date	Vaccine Type	Manufacturer	Lot Number	Expiration Date	Site

Vaccine Administrator:_____

Print Name:_____ **Date:**_____

Data Entry
OSIIS Complete
Initial_____

Total Wellness Corporate Health

2022 Consentimiento de los padres para vacunas

Be sure Parent circled "YES" before giving shot.

Laboratory Address: 7017 N. Robinson, Oklahoma City OK 73116 CLIA #37D2120685

Escuela/Ubicacion_____Nombre de Maestro/Grado_____

Complete toda la forma hasta la linea Amarilla y lleve a la recepcion **Fecha ____/_____/_____**

Nombre del estudiante	
Fecha de Nacimiento: ____/_____/_____	**☐ Masculino ☐ Femenino**
Domicillio:	
Ciudad Estado:	**State Oklahoma**
Codigo Postal	**Numero de Telefono de padre/madre:**

Proporcione informacion del seguro: Para obtener el numero de indentificacion de Soonercare: llame a 800-987-7767

Proveedor de Seguro	Numero de Indenticacion de miemb	Grupo/Numero	de poliza Asegurado principal Fecha de Nacimiento
			____/_____/_____

Race (please check one)				Ethnicity (please check one):	
☐	American Indian/Alaska Native	☐	White	☐	Hispanic or Latino
☐	Asian	☐	Other Race	☐	Not Hispanic or Latino
☐	Black or African American	☐	Patient Declines	☐	Unknown
☐	Native Hawaiian or Other Pacific Islander			☐	Patient Declines

Marque con un circulo Si o NO a cada una de las sigulentes preguntas:

1	¿Ha tenido alguna vez su hijo una reacción alérgica a una vacuna, huevos, algún medicamento o componente de la vacuna? En caso afirmativo, indique el tipo de reacción	Yes	No
2	¿Ha recibido su hijo alguna vacuna en las últimas 8 semanas? En caso afirmativo, indique qué vacuna(s):	Yes	No
3	¿Tiene su hijo la enfermedad de células falciformes? En caso afirmativo, ¿cuándo fue su última crisis de células falciformes? En caso afirmativo, ¿ha tenido fiebre o dificultad para respirar en las últimas 2 semanas?	Yes	No
4	¿Tiene su hijo antecedentes de cáncer, leucemia, SIDA/VIH, un trastorno muscular/del sistema nervioso, un trastorno convulsivo, síndrome de Gullain-Barre o cualquier otro trastorno del sistema inmunitario, autoinmune o cualquier otra afección crónica o a largo plazo? ?	Yes	No
5	¿Ha tomado su hijo aspirina diariamente, medicamentos antivirales, medicamentos contra el cáncer, esteroides para el cáncer, radioterapia, gammaglobulina inmune/inmune,una transfusión de sangre o algún producto sanguíneo en las últimas 8 semanas? En caso afirmativo, indique:	Yes	No
6	*Solo para mujeres* ¿Existe actualmente la posibilidad de que esté embarazada?	Yes	No

A continuación se enumeran las vacunas que se ofrecen hoy. Encierre en un círculo Sí en la vacunación indicada para su hijo.

Tdap (tétanos/difteria y tos ferina). SI **Meningococcal (Meningitis). SI**

Consiento y autorizo a mi hijo a recibir vacunas de Total Wellness sin mi presencia física. Soy el padre/tutor legal del niño mencionado anteriormente. Entiendo que Total Wellness se reserva el derecho de rechazar cualquier vacuna para el niño mencionado anteriormente si presenta un riesgo de pinchazo involuntario con la aguja para el personal o para sí mismo. He tenido la oportunidad de leer y hacer preguntas con anticipación relacionadas con los beneficios y los riesgos de las vacunas ofrecidas y reconozco comprensión. Visite los CDC para obtener las hojas de información sobre todas las vacunas que se ofrecen en https://www.cdc.gov/vaccines/hcp/vis/current-vis.html. Por la presente, autorizo al niño mencionado anteriormente a tener todas las vacunas que requiere el estado de Oklahoma para ingresar a la escuela y recibir las vacunas opcionales que he indicado al marcar

Firma del padre/tutor:_____ Fecha: _____/_____/_____

PLEASE COMPLETE EVERYTHING ABOVE THIS LINE AND RETURN TO REGISTRATION

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VFC Vaccines: VFC Vaccines MUST be Keyed into OSIIS!

Date	Vaccine Type	Manufacturer	Lot Number	Expiration Date	Site

Vaccine Administrator:_____

Print Name:_____ **Date:**_____

Data Entry
OSIIS Complete
Initial_____