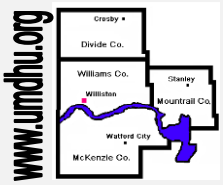

VACCINE CONSENT Upper Missouri District Health Unit

Vaccine Information Statements can be viewed at www.immunize.org/vis
Serving Divide, McKenzie, Mountrail and Williams Counties

PLEASE PRINT ***Answer health questions on the top back of this sheet.***

CLIENT INFORMATION

First Name:	Middle Name:	Last Name:	Date of Birth:	Age:	Gender: *(circle)* Male Female

Mailing Address:

City:

State: **Zip Code:** **County:**

Email:

Race: ***(please check all that apply)***

- ☐ White but not Hispanic or Latino
- ☐ White and Hispanic or Latino
- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian / Pacific Islander
- ☐ Other race
- ☐ Unknown

Birth State:

or Birth Country:

Home Phone #	Cell Phone#	Work #

ELIGIBILITY

Please check *all* that apply.

☐ _____ **Medicaid [NUMBER REQUIRED]** **Self Pay:** _____
DO NOT SEND MONEY. Medicaid will be billed ***if Medicaid number is provided.*

☐ **No Insurance** **SEND **$20.99 FOR EACH VACCINATION** with this consent form (exact cash or check, payable to UMDHU)*

☐ **Insured – Call your insurance company to determine if vaccines are covered when provided by Upper Missouri District Health Unit**. If it is, fill out insurance information. **DO NOT SEND MONEY.* You will be billed for any patient responsibility. Call your local UMDHU office for further questions or payment options.

INSURANCE INFORMATION

Primary Insurance or Medicare #

Policy Holder Name (First MI Last):	Policy Holder Relationship to Client:	Policy Holder Date of Birth:

Insurance Company Name :	Group # if applicable:	Policy Holder Gender: Male Female

Policy Holder Member ID #:	Client Member ID # if different:

Secondary or Supplemental Insurance

Policy Holder Name (First MI Last):	Policy Holder Relationship to Client	Policy Holder Date of Birth:

Insurance Company Name :	Group # is applicable:	Policy Holder Gender: Male Female

Policy Holder Member ID #:	Client Member ID # if different:

	Company Pay Name:	Company Mailing Address:

SIGNATURE

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I consent to the administration of the vaccine(s) to be given. A copy of the Vaccine Information Statement has been provided. I have read the information about the vaccine. I had an opportunity to ask questions and believe I understand the benefits and risks of the vaccine.
Information collected on this form will be used to document receipt of vaccine and I consent to the exchange of this information with the ND Immunization Information System.
I agree to pay and am financially responsible for charges not covered by third-party payers. I assign and authorize any third party payer/insurer to make direct payment to Upper Missouri District Health Unit (UMDHU)). I authorize the release of information necessary to process this claim. UMDHU Notice of Privacy Practices is available on request.

SIGNATURE OF CLIENT or Person Authorized to Sign on the Client's Behalf DATE

Please answer health questions on the back of this sheet.

HEALTH HISTORY

Please answer the questions below for the person receiving vaccine.

	✓Check Yes or No
Is the client sick today?	☐Yes ☐ No
Does the client have allergies to medications, food, a vaccine component, or latex?	☐Yes ☐ No
Has the client had a serious reaction to a vaccine in the past?	☐Yes ☐ No
Has the client had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder?	☐Yes ☐ No
Children only: child on long-term aspirin therapy? *Babies only*: has baby had intussusception (bowel obstruction)?	☐Yes ☐ No
Has the client, a sibling, or parent had a seizure; has the client had brain or other nervous system problems or Guillain-Barré (paralyzing polio)?	☐Yes ☐ No
Does the client have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐Yes ☐ No
In the past 3 months, has the client taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis or had radiation treatments?	☐Yes ☐ No
In the past year, has the client received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐Yes ☐ No
Is the client pregnant or is there a chance client could become pregnant during the next month?	☐Yes ☐ No
Has the client received vaccinations in the past 4 weeks?	☐Yes ☐ No
Has the client had the chickenpox disease? If yes when? _____	☐Yes ☐ No
Does the client use Tobacco or e-cigarettes?	☐Yes ☐ No
Has the client been exposed to any second hand smoke?	☐Yes ☐ No

PARENT: Circle the vaccine(s) you want your child to be given or circle ALL VACCINES:

ALL VACCINES DUE OR

Circle individual vaccines to be given: **Rotavirus Act Hib Polio DTaP HIB PCV13 Hepatitis A Hepatitis B Chickenpox HPV MCV4 MenB MMR Tdap Influenza**

BELOW IS UPPER MISSOURI DISTRICT HEALTH UNIT USE ONLY **Name:**

Refused to answer question ☐ Advised to quit ☐ Cessation referral/education offered ☐

	Vaccine(s) To Be Given		CVX	CPT	Route	Lot Number	Admin Site
P / VFC	**Influenza**	Fluarix PF – 6 mo & up	150	90686	IM		LA RA LT RT
P	**Influenza-High Dose**	Fluzone – 65 yrs +	135	90662	IM		LA RA LT RT
P / VFC	**Influenza** –	multi-dose vial		90686	IM		LA RA LT RT
P / VFC	**Rotavirus**	Rotarix-2 Dose	116	90681	Oral		Oral
P / VFC	**Act Hib**		49	90648	IM		LA RA LT RT
P / VFC / 317	**Chickenpox**	Varicella	21	90716	SQ		LA RA LT RT
P / VFC	**DTaP**	Diphtheria-Tetanus-Pertussis	20	90700	IM		LA RA LT RT
P / VFC	**DTaP/IPV**	Kinrix	130	90696	IM		LA RA LT RT
P / VFC	**DTap/IPV/HBV**	Pediarix	110	90723	IM		LA RA LT RT
P / VFC	**Hepatitis A** *Pediatric*	12 mo -18 yr	83	90633	IM		LA RA LT RT
P / VFC	**Hepatitis A** *Adult*	19 yrs & up	52	90632	IM		LA RA LT RT
P / VFC	**Hepatitis B** *Pediatric*	Birth – 19 yr	08	90744	IM		LA RA LT RT
P / VFC / 317	**Hepatitis B** *Adult*	20 yrs & up	43	90746	IM		LA RA LT RT
P / VFC / 317	**HPV9**	Gardasil	165	90651	IM		LA RA LT RT
P / VFC	**IPV**	Polio	10	90713	IM		LA RA LT RT
P / VFC / 317	**MCV-4**	Menveo	136	90734	IM		LA RA LT RT
P / VFC / 317	**MenB**	Bexsero	163	90620	IM		LA RA LT RT
P / VFC / 317	**MMR**	Measles-Mumps-Rubella	03	90707	SQ		LA RA LT RT
P / VFC	**MMRV**	MMR-Varicella	94	90710	SQ		LA RA LT RT
P / VFC / 317	**PCV13**	Prevnar	133	90670	IM		LA RA LT RT
P / VFC / 317	**PPSV23**	Pneumovax	33	90732	IM		LA RA LT RT
P / VFC / 317	**Td**		113	90714	IM		LA RA LT RT
P / VFC / 317	**Tdap**		115	90715	IM		LA RA LT RT
P	**Yellow Fever**		37	90717	SQ		LA RA LT RT
P	**Japanese Encephalitis**		134	90738	IM		LA RA LT RT
P	**Typhoid**		101	90691	IM		LA RA LT RT
P	**Rabies**		18	90675	IM		LA RA LT RT
Vaccine Administrator:					**Date Given:**		

Amt Paid	Cash check	Check #	Credit Card	Demo	NDIIS	IMM widget	Note/ESB	ESB √	Pmt Post'd	Revised 9/13/2018