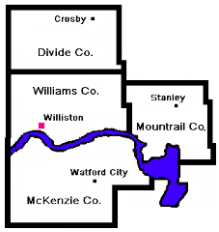
www.umdhu.org



Flu Administration Record

Information collected on this form will used to document authorization of receipt of vaccine(s). Information may be shared through the North Dakota Immunization Information system (NDIIS) with other entities in accordance with North Dakota Century Code 23-01-05.3.

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 (Street or Box Number):	Apt Number	Race: *(please check all that apply)*	Birth State or Birth Country:
City:		☐ 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	
State: / Zip Code:	County:		Occupation:
Email:			

Home Phone #	Cell Phone#	Work #

ELIGIBILITY

Please check *all* that apply. The information below pertains to the influenza immunization only.

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

☐ **No Insurance (18 and under)** ****SEND $20.99 FOR FLU VACCINATION** with this consent form (exact cash or check, payable to UMDHU)*

☐ **Self-Pay :** _____

☐ **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: PRINT NAME:	Date:

First Name:	Middle Name:	Last Name:	Date of Birth:	Age:

For patients to be vaccinated: The following questions will help us determine if there is any reason, we should not give you inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Select the vaccine(s) you want to be given: **Influenza:** ☐ **High Dose (ages 65+)** ☐ **Influenza (all ages 6months+)**

Y____N____ Do you feel sick today?
Y____N____ Have you had a serious reaction from a previous vaccination?
Y____N____ Do you have a history of severe allergic reaction (anaphylaxis) to any component of the vaccine including egg protein?
Y____N____ Have you had Guillain-Barré Syndrome, a rare paralyzing illness?
Y____N____ Do you have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome? Do not include high Blood Pressure.
Y____N____ Do you use tobacco?

BELOW IS FOR UMDHU USE ONLY

	Vaccine	CVX	Lot #	Site	Age
P/ VFC	Fluarix PF	150		LA RA LT RT	6 mos & up
P/ VFC	Fluzone PF	150		LA RA LT RT	6 mos & up
P/ VFC	Flucelvax	171		LA RA LT RT	2 yrs & up
	High Dose Fluzone	135		LA RA	65 years & up

Vaccine Administrator		Date Given	

Amt Paid	Cash	Credit Card	Check #	DEMO	Ins Elg.	Imm Widget	Note/ESB	ESB	Pmt Posred	NDIIS	Revised 9/16/21