



Flu /COVID Administration Record

Information collected on this form will be 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 <u>all</u> that apply)		Birth State or Birth Country:
City:			<input type="checkbox"/> White but not Hispanic or Latino <input type="checkbox"/> White and Hispanic or Latino <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> Other race <input type="checkbox"/> Unknown		Occupation:	
State:	Zip Code:	County:				
Email:						
Home Phone #			Cell Phone#	Work #		

ELIGIBILITY

Please check all that apply. The information below pertains to the influenza immunization only. There is no cost for the COVID vaccine at this time.

_____ 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:	<input type="checkbox"/> High Dose (ages 65+)
		<input type="checkbox"/> Influenza (all ages 6months+)
	COVID:	<input type="checkbox"/> Pfizer (12-17 years old will be given Pfizer only)
		<input type="checkbox"/> Moderna
		<input type="checkbox"/> Janssen

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?

-----**Answer these additional Questions if Receiving COVID vaccine today**-----

Y ___ N ___ Have you received a dose of COVID vaccine? Circle which one: Pfizer Moderna Janssen

Y ___ N ___ Have you received monoclonal antibodies or convalescent plasma for COVID treatment in past 90 days?

Y ___ N ___ Have you tested positive for COVID in the past 10 days?

Y ___ N ___ Do you have a weakened immune system caused by HIV infection or cancer or do you take immunosuppressive drugs or therapies?

Y ___ N ___ Do you have dermal fillers?

Y ___ N ___ Have you ever had a **severe** allergic reaction (anaphylaxis) to anything? **List:** _____

Vaccine	CVX	Lot #	Site	Age
Fluarx PF	150		LA RA LT RT	6 mos & up
Fluzone PF	150		LA RA LT RT	6 mos & up
Flucelvax	171		LA RA LT RT	2 yrs & up
High Dose Fluzone	135		LA RA	65 years & up
COVID Moderna	207		LA RA	Dose: 1 2 3
COVID Pfizer	208		LA RA	Dose: 1 2 3
COVID Janssen	212		LA RA	Dose: 1 2

BELOW IS FOR UMDHU USE ONLY

Vaccine Administrator					Date Given						
Amt Paid	Cash	Credit Card	Check #	DEMO	Ins Elg.	Imm Widget	Note/ESB	ESB √	Pmt Post'd	NDIIS	Revised 9/16/21
									Claim Closed		