



# VACCINE CONSENT Upper Missouri District Health Unit

Vaccine Information Statements can be viewed at [www.immunize.org/vis](http://www.immunize.org/vis)  
Serving Divide, McKenzie, Mountrail and Williams Counties

**PLEASE PRINT**

CLIENT INFORMATION

First Name:		Middle Name:	Last Name:	Date of Birth:	Age:	Gender: (circle) Male Female
Mailing Address:			APT	Race: (please check <u>all</u> that apply)		Birth State:
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		or  Birth Country:	
State:	Zip Code:	County:				
Email:						
Home Phone #			Cell Phone#	Work #		

ELIGIBILITY

**Please check:**

\_\_\_\_\_ Medicaid [NUMBER REQUIRED] - Medicaid will be billed **if** Medicaid number is provided

Self Pay (Insurance not filed thru UMDHU) Adults/Children - Cost of Administration Fee plus Cost of Vaccine

No Insurance: Adults - Cost of Administration Fee plus Cost of Vaccine

No Insurance - 18 years and under - **-\$20.99 FOR EACH VACCINATION** (exact cash or check, payable to UMDHU)

No Insurance -317 Vaccine - Adults **-\$20.99 Adm Fee FOR EACH VACCINATION** (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: PRINT NAME: \_\_\_\_\_

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

**Please answer health questions on the back of this sheet.**

**PARENT:** Circle the vaccine(s) you want your child to be given below:

**ALL VACCINES DUE OR Circle individual vaccines to be given:** Rotavirus Act Hib Polio DTaP PCV13

Hepatitis A Hepatitis B Chickenpox HPV MCV4 Men B MMR Tdap Influenza Vaxelis COVID

Please answer the questions below for the person receiving vaccine.	✓ Check Yes or No
Is the client sick today?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the client had a serious reaction to a vaccine in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the client had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Children only:</i> child on long-term aspirin therapy? <i>Babies only:</i> has baby had intussusception (bowel obstruction)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the client pregnant or is there a chance client could become pregnant during the next month?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the client received vaccinations in the past 4 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client use Tobacco or e-cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the client been exposed to any second-hand smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No

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

	Vaccine(s) To Be Given	CVX	CPT	Route	Lot Number	Admin Site
P /VFC	Influenza Fluorix PF – 6 mos & 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	Influenza Flucelvax – 2 yrs & up	171	90674	IM		LA RA LT RT
P /VFC	Rotavirus Rotarix-2 Dose	119	90681	Oral		Oral
P /VFC	Act Hib Haemophilus influenzae type b	48	90648	IM		LA RA LT RT
P /VFC	Chickenpox Varicella	21	90716	SQ		LA RA LT RT
State	Covid (12 yrs and Older) Moderna	207	91301	IM		LA RA LT RT
State	Covid Moderna Booster Doses	207	91306	IM		LA RA LT RT
State	Covid (12 yrs and older – Gray Cap) Pfizer	217	91300	IM		LA RA LT RT
State	Covid Pediatric (5-11 years old) Pfizer	218	91307	IM		LA RA LT RT
State	Covid Pediatric (6 mos – 4 yrs old) Pfizer	219	91308	IM		LA RA LT RT
State	Covid Janssen	212	91303	IM		LA RA LT RT
State	Novavax (18 yrs and older) Novavax	211	91304	IM		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	DTap/IPV/HBV/Hib Vaxelis	146	90697	IM		LA RA LT RT
P /VFC	Hepatitis A Pediatric 12 mos -18 yrs	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 yrs	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	Men B 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
State	Monkey Pox	206	90611	SQ		LA RA LT RT
P /VFC / 317	PPSV23 Pneumovax	33	90732	IM		LA RA LT RT
P /VFC / 317	PCV 20 Pneumococcal	216	90677	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
P	Zoster Shingrix - Shingles	187	90750	IM		LA RA LT RT

Vaccine Administrator:

Date Given:

Revised 7/22