www.umdhu.org

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 – Upper Missouri District Health Unit direct bills BCBS, United Healthcare, Meritain, Medica and Sanford Insurance Plans.** Please fill out insurance information below. If you have an insurance plan not listed above contact UMDHU for a total to send with your child.

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) series to be given for the 2019-2020 school year. I understand that it is my responsibility to contact UMDHU if my child has a change in their health history or if I would like to discontinue a series. 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.

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

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 MenB MMR Tdap Influenza

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

BELOW IS UPPER MISSOURI DISTRICT HEALTH UNIT USE ONLY

	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	119	90681	Oral		Oral
P / VFC	**Act Hib**		48	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 / 317	**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 6/3/2019