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

CLIENT INFORMATION

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

Mailing Address:	APT	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:			
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 –** ***DONATION FOR EACH VACCINATION*** *(exact cash or check, payable to UMDHU)*

☐ **No Insurance -317 Vaccine – Adults -*DONATION 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 RSV COVID

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
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 PF (6 mos & up)**	Fluarix	150	90686	IM		LA RA LT RT
P	**Influenza-High Dose (65 yrs +)**	Fluzone	197	90662	IM		LA RA LT RT
P /VFC	**Influenza (2 yrs & up)**	Flucelvax	171	90674	IM		LA RA LT RT
P /VFC	**Rotavirus**	Rotarix-2 Dose	119	90681	Oral		Oral
P /VFC	**Act Hib**	Haemophlilus influenzae type b	48	90648	IM		LA RA LT RT
P /VFC	**Chickenpox**	Varicella	21	90716	SQ		LA RA LT RT
P /VFC	**Covid Moderna (6mos-11ys)**	Moderna	311	91321	IM		LA RA LT RT
P /VFC	**Covid Moderna (12 yrs & up)**	Moderna	312	91322	IM		LA RA LT RT
P /VFC	**Covid Pfizer(6 mos to 4 yrs)**	Pfizer	308	91318	IM		LA RA LT RT
P /VFC	**Covid Pfizer (5 yrs to 11yrs)**	Pfizer	310	91319	IM		LA RA LT RT
P /VFC	**Covid Pfizer (12 yrs & up)**	Pfizer	309	91320	IM		LA RA LT RT
P /VFC	**Novavax (12 yrs &up)**	Novavax	313	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
P /VFC / 317	**PCV13**	Prevnar	133	90670	IM		LA RA LT RT
P /VFC / 317	**PCV20**	Prevnar	216	90677	IM		LA RA LT RT
P /VFC / 317	**PPSV23**	Pneumovax	33	90732	IM		LA RA LT RT
P /VFC	**RSV Adult**	Arexy	303	90679	IM		LA RA LT RT
P /VFC /317	**Tdap**		115	90715	IM		LA RA LT RT
P	**Zoster Shingrix - Shingles**		187	90750	IM		LA RA LT RT
P /VFC	**RSV Infant**	Niresvimab	307	90381	IM		LA RA LT RT
							LA RA LT RT
							LA RA LT RT

Vaccine Administrator: **Date Given:**

Revised 09/23