First District Health Unit FLU REGISTRATION & CONSENT

PLEASE PRINT. Use full, legal name.

FIRST NAME_____ **M.I.** _____ **LAST NAME**_____

DATE OF BIRTH _____ **AGE**_____ **M**_____ **F**_____ **PHONE**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

RACE Circle all that apply White American Indian African American Alaska Native Asian Hispanic/Latino Pacific Islander Other Unknown

MEDICARE or MEDICAID #:_____

If Medicare Advantage Plan circle: Humana GOLD or Medica Advantage. ID #:_____ Group #:_____

INSURANCE COMPANY: _____ Payer ID / EDI #:_____back of card

Policy Holder: Name (First MI Last): _____ Date of Birth: _____

Gender: Male / Female Relationship to client:_____ Group #_____

Policy Holder ID #:_____ Client ID # (if different): _____

Tricare use 11 digit **Benefits Number** on ***Back of Card***: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ **Do not have insurance** ☐**Mark if 2nd insurance info written on the back.**

☐ **Approved to Bill Employer: Employer Name**_____

Y____N____ Do you feel sick today?

Y____N____ Have you had a serious reaction from a previous vaccination?

Y____N____ Are you allergic to latex, food, or medicine? **List allergies**_____

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, or a blood disorder? (not including high Blood Pressure)

Y____N____ Do you use tobacco?

Also answer these questions if receiving Shingrix or Tdap/Tetanus vaccines:

Y____N____ Have you had a seizure or a brain or other nervous system problem?

Y____ N____ In past 3 months, taken meds that affect immune system (prednisone, steroids, anticancer); or meds for treatment of rheumatoid arthritis, Crohn's, psoriasis; or had radiation treatments?

A copy of the **Vaccine Information Statement(s) has been provided.** I have read, or had explained, the information about the vaccine(s). I had an opportunity to ask questions and believe that I understand the benefits and risks of the vaccine(s)**. I consent to the administration of the vaccines listed to be given to the person named above.** FDHU **Notice of Privacy Practices** is available online or by request. **I agree to pay and I am financially responsible** for charges not covered by a third-party payer. I assign and **authorize any third party payer/insurer** to make direct payment to FDHU. I authorize the release of information necessary to process this claim**.** Information will be shared with the ND Immunization Information System.

SIGNATURE OF CLIENT OR PERSON AUTHORIZED TO CONSENT ON THE CLIENT'S BEHALF TO RECEIVE VACCINATION:

X_____**DATE:**_____

FOR FDHU STAFF USE ONLY

BCBS, Sanford, Tricare, Medica, Meritain and Preferred One are network insurances. (NOT Sanford True or United Healthcare)

☐ Private Vaccine ☐ VFC Vaccine ☐Adult 317 Flu

Vaccine	CVX	Lot #	Site	Ages
FluLaval syringe	150		LA RA LT RT	6 months & up
FluLaval vial	158		LA RA LT RT	
High Dose	168		LA RA	65 years & up
Adult 317 Flu	171		LA RA	19 years & up

Vaccine	CVX	Lot #	Site
PPV23	33		LA RA
PCV13	133		LA RA
Tdap	115		LA RA
Shingrix	187		LA RA

Vaccine Administrator Initials		Date Given	

Amt Paid	Cash / Credit Card	Check #	Transact RX	Pmt Post'd	Demo	IMM widget	Note done/sent	ESB √	Revised 8/13/19