



**FDHU will be giving flu vaccine at the schools this fall.  
The flu shot will be the only form of vaccine available.**

For dates of clinics  
please check our  
website  
fdhu.org

To receive a flu vaccination, complete consent and return to the **school ASAP**

**If you do NOT want your child to receive flu vaccine, do NOT fill out or return form**

**PLEASE PRINT neatly in ink. Use full, legal name of person receiving vaccine.**

**FIRST NAME** \_\_\_\_\_ **M.I.** \_\_\_\_\_ **LAST NAME** \_\_\_\_\_

**DATE OF BIRTH** \_\_\_\_\_ **AGE** \_\_\_\_\_ **M** \_\_\_ **F** \_\_\_ **PHONE** daytime \_\_\_\_\_  **CELL** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_

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

Student's: Parent Name \_\_\_\_\_

School Name \_\_\_\_\_ Grade \_\_\_\_\_ Elementary Teacher \_\_\_\_\_

**Answer health questions for person getting flu vaccination**

Y \_\_\_ N \_\_\_ Had a serious reaction from a previous flu vaccination?

Y \_\_\_ N \_\_\_ Allergic to latex, food, or medicine? **List allergies:** \_\_\_\_\_

Y \_\_\_ N \_\_\_ Had Guillain-Barré Syndrome, a temporary severe muscle weakness?

**BCBS, Sanford, Tricare, United Healthcare, Medica, Meritain and Preferred One are network insurances. (NOT Sanford True.) You will be billed \$52 if your insurance denies the claim or the form is turned in with incomplete insurance information.**

**MEDICAID OR MEDICARE NUMBER:** \_\_\_\_\_

**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** (Under 18 years will be billed \$20.90)                       **Attached copy of 2<sup>nd</sup> insurance, if applicable**

I have viewed the Vaccine Information Statement at [www.immunize.org](http://www.immunize.org) or viewed a hard copy by calling First District Health Unit at 701-852-1376. I have read 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 & am authorized to give consent.** 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									
Lot #		Site RA LA		<input type="checkbox"/> Private Vaccine <input type="checkbox"/> VFC Vaccine    Student/Staff feeling well today?    Yes    No Child is 8 years old or younger.    Child needs a 2nd dose of flu vaccine.    Yes    No					
Vaccine Administrator Initials				Date given					
Amt Paid	Cash Credit Card	Check #	Transact RX	Pmt Post'd	Demo	IMM widget	Note done/sent	ESB ✓	Revised 08/13/20