VACCINE CONSENT First District Health Unit

Vaccine Information Statements can be viewed at www.immunize.org/vis

Serving Bottineau, Burke, McHenry, McLean, Renville, Sheridan & Ward

PLEASE PRINT ***Answer health questions on the top back of this sheet.***

CLIENT INFORMATION

First Name: Use full legal name	**MI:**	**Last Name:** Use full legal name	**Date of Birth:**	**Age:**	**Gender:** *(circle)* Male Female

Mailing Address:

City:

State: | **Zip Code:** | **County:**

Race: ***(please check all that apply)***

- ☐ White
- ☐ Hispanic or Latino
- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian / Pacific Islander
- ☐ Other race
- ☐ Unknown

Home or Cell Phone # (Best daytime #) | **Alternate #**

ELIGIBILITY

Please check *all* that apply.

☐ _____ **Medicaid [NUMBER REQUIRED]**
DO NOT SEND MONEY. Medicaid will be billed ***if Medicaid number is provided.***

☐ **No Insurance** **SEND **$20.90 FOR EACH VACCINATION** with this consent form (exact cash or check, payable to FDHU)*

☐ **Insured – Call your insurance company to determine if vaccines are covered when provided by First 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 FDHU office for further questions or payment options.

INSURANCE INFORMATION

Primary Insurance

Policy Holder Name (First MI Last):	**Policy Holder Relationship to Client:**	**Policy Holder Date of Birth:**	**Policy Holder Gender:** Male Female

Insurance Company Name : | **Group #** if applicable: | **Payer ID or EDI # -** back of card

Policy Holder Member ID #: | **Client Member ID #** if different:

If you have a secondary insurance, please attach a sheet with the insurance information as listed above.

Tricare

Tricare Only:

Sponsor's Name (First MI Last):	**Relationship to Client:**	**Sponsor's Date of Birth:**	**Sponsor's Gender:** Male Female

Tricare Benefit # (11 digits on back of card): Not the identification number

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 shared 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 First District Health Unit (FDHU). I authorize the release of information necessary to process this claim. FDHU Notice of Privacy Practices is available on request or online at www.fdhu.org.

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

Please answer health questions on the back of this sheet.

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? *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 she 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

PARENT: Circle the vaccine(s) you want your child to be given or circle ALL VACCINES:

ALL VACCINES DUE OR circle individual vaccines to be given:

Chickenpox DTaP Hepatitis A Hepatitis B HIB HPV MCV4 MenB MMR Polio PCV13 Rotavirus Tdap

FIRST DISTRICT OFFICE USE ONLY

BELOW IS FIRST DISTRICT OFFICE USE ONLY **Name:**

Refused to answer question ☐ Advised to quit ☐ Cessation referral/education offered ☐

☐ **VFC Vaccine:** Medicaid, American Indian, No Insurance, Underinsured ☐ ***Private Vaccine*** Not Eligible in NDIIS

	Vaccine(s) To Be Given	CVX	CPT	Lot Number	Admin Site	Nurse
	Bexsero **MenB**	163	90620		LA RA	
	Chickenpox Varicella	21	90716		LA RA	
	DTaP Diphtheria-Tetanus-Pertussis	20	90700			
	DTaP/IPV Kinrix	130	90696		LA RA	
	DTaP/IPV/HBV Pediarix	110	90723			
	HepA/HepB Twinrix	104	90636		LA RA	
	Hep A *Pediatric* 12 mo -18 yr	83	90633		LA RA	
	Hep A *Adult* 19 yrs & up	52	90632		LA RA	
	Hep B *Pediatric* Birth – 19 yr	08	90744		LA RA	
	Hep B *Adult* 20 yrs & up	43	90746		LA RA	
	Hep B *Adult* Heplisav-B 18 yrs & up	189	90739		LA RA	
	HIB PedVax	49	90647			
	HPV9 Gardasil	165	90651		LA RA	
	Influenza				LA RA	
	IPV Polio	10	90713		LA RA	
	MCV-4 Menveo	136	90734		LA RA	
	MMR Measles-Mumps-Rubella	03	90707		LA RA	
	MMRV MMR-Varicella	94	90710		LA RA	
	PCV13 Prevnar	133	90670			
	PPSV23 Pneumovax	33	90732		LA RA	
	Rotavirus	116	90680			
	RZV Shingrix	187	90750		LA RA	
	Td	113	90714		LA RA	
	Tdap	115	90715		LA RA	
	Trumenba **MenB**	162	90621		LA RA	

Vaccine Administrator: Date given:

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