McIntosh District Health Unit
511 3rd Ave NW
Ashley, ND 58413
701-288-3957

Flu SHOT Consent Form

Patient Name: _____ Date of Birth: _____ Age: _____

Address and Town: _____ Phone: _____

___Medicare or Medicaid # _____ _____Does not have health Insurance

___Health Insurance Policy # _____
Policy Holder Name: _____Policy Holder Date of Birth: _____
Policy Holder Address (if different from patient):
_____

___Cash Payment $40 per shot (due at time of service if no insurance)

Flu Shot

Please Check "YES" or "NO" for each question:	Yes	No
▪ Does the person to be vaccinated have an allergy to eggs, or to a component of the vaccine?		
▪ Does the person to be vaccinated have an allergy to latex?		
▪ Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?		
▪ Does the person to be vaccinated have a history of Guillain-Barre Syndrome?		
If you answered YES to any of the above questions the person is not eligible to receive the flu shot		

I authorize the release of any medical or other information necessary to process a health insurance claim form. Information may be shared through the NDIIS with other entities in accordance with ND Century Code. I have read the Vaccine Information Statement for Inactivated Influenza Vaccine and am aware of the contraindications and risks of each. I consent for myself/Child to receive the flu vaccine.

_____ _____
Individual or Parent Signature Date

To be filled out by nurse:

VACCINE TYPE:

☐ Flulaval (6 months and older) (GSK)
☐ Flucelvax (4 years and older, egg free) (FFF)

Additional Family Members (Use **ONLY** if all insurance information is the same)

Patient Name	Patient DOB	Medicaid #	Manufacturer	Lot Number	Private or State	Admin. Site
					P S	LA RA LT RT
Patient Name	Patient DOB	Medicaid #	Manufacturer	Lot Number	Private or State	Admin. Site
					P S	LA RA LT RT

Nurse Signature:_____ ***Date Given:_____***

Updated 9/12/2018