www.umdhu.org

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

PLEASE PRINT

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] –** *North Dakota Medicaid will be billed* ***if*** *number is provided*

☐ **Self-Pay (Insurance not filed thru UMDHU) Adults/Children –** Please contact 701-444-3449 for exact payment

☐ **No Insurance – 18 years and under -** ***$20.99 FOR EACH VACCINATION*** *(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 (701-444-3449) 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: DATE

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

Please answer health questions on the back of this sheet.

First Name:	Middle:	Last Name:	Date of Birth: ___/___/___	Age:

Indicate yes or no for each listed vaccine. Please note that age ranges listed, may not be everything your child is due for if they were not previously fully vaccinated. You may select yes for everything, if you wish for your child to receive all vaccines they are eligible for. If you mark yes for a vaccine your child is currently up to date on, we will not administer that vaccine.

Additional Vaccines due by age: →					4 or older				11 or older			16 or older	
	Influenza	COVID	Hep A	Hep B	DtaP	IPV	MMR	Varicella	Tdap	MCV	HPV	MCV	Men B
Yes													
No													

Please answer the questions below for the person receiving vaccine.	✓Check
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**	Fluarix PF – 6 mos & up	150	90686	IM		LA RA LT RT
P /VFC	**Influenza**	Flucelvax – 2 yrs & up	171	90674	IM		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 and older)**	Novavax	313	91304	IM		LA RA LT RT
P /VFC	**Chickenpox**	Varicella	21	90716	SQ		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	**Tdap**		115	90715	IM		LA RA LT RT

Vaccine Administrator:		**Date:**	

Amt Paid	Cash	Credit Card	Check #	DEMO	Ins Elg.	Imm Widget	Note	ESB √	Pmt Post'd	Claim Closed	NDIIS	Revised 04/2024