www.umdhu.org

Flu /COVID Administration Record

Information collected on this form will used to document authorization of receipt of vaccine(s). Information may be shared through the North Dakota Immunization Information system (NDIIS) with other entities in accordance with North Dakota Century Code 23-01-05.3.

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

CLIENT INFORMATION

First Name:	Middle Name:	Last Name:	Date of Birth:	Age:	Gender: *(circle)* Male Female

Mailing Address (Street or Box Number):	Apt Number	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:			Occupation:
Email:			

Home Phone #	Cell Phone#	Work #

ELIGIBILITY

Please check *all* that apply.

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

☐ **No Insurance (18 and under)** ****SEND $20.99 FOR FLU VACCINATION***
with this consent form (exact cash or check, payable to UMDHU)

☐ **Self-Pay :** _____

☐ **Insured** –You will be billed for any patient responsibility.
Fill out insurance information for:
MEDICARE, BCBS, SANFORD, MEDICA, UNITED, MERITAIN, AETNA
Call your local UMDHU office for further questions or payment options.

Call your insurance company to determine if vaccines are covered when provided by Upper Missouri District Health Unit.

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:		

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:

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

Select the vaccine(s) you want to be **given:**

Influenza:
- ☐ **High Dose (ages 65+)**
- ☐ **Influenza (all ages 6months+)**

COVID:
- ☐ **Pfizer**
- ☐ **Moderna**
- ☐ **Novavax**

Y____N____ Do you feel sick today?
Y____N____ Have you had a serious reaction from a previous vaccination?
Y____N____ Do you have a history of severe allergic reaction (anaphylaxis) to any component of the vaccine including egg protein?
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, a blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome? Do not include high Blood Pressure.
Y____N____ Do you use tobacco?

--------Answer these additional Questions if Receiving COVID vaccine today ----------

Y____N____ Have you received a dose of COVID vaccine? Circle which one: Pfizer Moderna Janssen Novavax
Y____N____ Have you received monoclonal antibodies or convalescent plasma for COVID treatment in past 90 days?
Y____N____ Have you tested positive for COVID in the past 10 days?
Y____N____ Do you have a weakened immune system caused by HIV infection or cancer or do you take immunosuppressive drugs or therapies?
Y____N____ Do you have dermal fillers?
Y____N____ Have you ever had a **severe** allergic reaction (anaphylaxis) to anything? **List:** _____

BELOW IS FOR UMDHU USE ONLY

	Vaccine	CVX	CPT	Route	Lot #	Site
P/VFC	**Fluarix PF (6 mos & up)**	140	90656	IM		LA RA LT RT
P/VFC	**FLUZONE (6 mos & up)**	140	90656	IM		LA RA LT RT
P/VFC	**Flucelvax PF (6 mos & up)**	153	90611	IM		LA RA LT RT
P/VFC	**Flucelvax (6 mo & up multi dose)**	320	90611	IM		LA RA LT RT
P/VFC	**Afluria PF 3 Yrs. +**	140	90656	IM		LA RA LT RT
P/VFC	**Afluria 6-35 Mos.**	141	90657	IM		LA RA LT RT
P/VFC	**Afluria W/P 3 Yrs. + Mulit Dose**	141	90658	IM		LA RA LT RT
P	**High Dose Fluzone (65 years & up)**	135	90622	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	**Covid** **Novavax**	313	91304	IM		LA RA LT RT

Vaccine Administrator		Date Given	

Amt Paid	Cash	Credit Card	Check #	DEMO	Ins Elg.	Imm Widget	Note	ESB √	Pmt Post'd	Claim Closed	NDIIS	Revised 9/24