First District Health Unit (FDHU) VACCINE CONSENT

Information is for the person receiving the vaccine. Please print. Use full legal name.

First Name: ________________________ MI: ___ Last: ________________________ Date of Birth: _________

Mailing Address: ____ Phone: ___________________

Age: _____ County: _____________ Email: ____________________________________ May be used to access Patient Portal

Gender: Female Male **Race:** Circle all that apply White American Indian African American Alaskan Native Asian Hispanic/Latino Pacific Islander Other Unknown

INSURANCE/MEDICAID: _____________________________________ Policy Holder ID #*: ______________________

Policy Holder: Name (First MI Last): ____ Date of Birth: ________________

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 2nd insurance, if applicable**

Health Questions for the person receiving the vaccine.	
1. Feel sick today?	☐ Yes ☐ No
2. List allergies to medications, food, a vaccine component, or latex.	☐ Yes ☐ No
3. Ever had a serious reaction to a vaccine in the past?	☐ Yes ☐ No
4. Have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder?	☐ Yes ☐ No
5. Had brain or other nervous system problems, or Guillain-Barré (a paralyzing polio)?	☐ Yes ☐ No
6. Have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐ Yes ☐ No
7. In the past 3 months, 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
8. In the past year, received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐ Yes ☐ No
9. Had vaccinations in the past 4 weeks?	☐ Yes ☐ No
10. Use Tobacco or e-cigarettes?	☐ Yes ☐ No
11. *Females only:* pregnant or is there a chance she could become pregnant during the next month?	☐ Yes ☐ No
12. *Children only*: Has child or their sibling, or their parent had a seizure?	☐ Yes ☐ No
13. *Babies only* (under 8 months): had intussusception (bowel obstruction)?	☐ Yes ☐ No

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

ALL VACCINES DUE OR: Chickenpox DTaP Hepatitis A Hepatitis B HPV MCV4 MenB MMR Polio Tdap

I have viewed the Vaccine Information Statement at www.immunize.org or viewed a hard copy by calling FDHU office. I have read the information about the vaccine(s). I had an opportunity to ask questions and believe I understand the benefits and risks of the vaccine(s**)**. **I consent to the administration of the vaccines circled 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:**_____________________

FIRST DISTRICT OFFICE USE ONLY:

Name: ____ Age: _____________

☐ ***VFC:*** Medicaid, American Indian, No insurance, Underinsured ☐ **Private Vaccine** & ADULT Medicaid (Incudes HPV)

☐ **317**: Underinsured/No insurance HPV (19 – 26yrs), MCV4, MMR, Td, Tdap. Plus Hep A, Hep B, Twinrix - not for travel.

	VACCINE		AGES	CVX	LOT	SITE	Route	INITIAL
	Bexsero	MenB	*16 yr thru 23 yr*	163		LA RA	IM	
	DTaP		*under 7yr*	20		LA RA LT RT	IM	
	DTaP/IPV	**Kinrix**	*4 thru 6 yr*	130		LA RA LT RT	IM	
	DTaP/IPV/HBV	**Pediarix**	*Under 7 yr*	110		LA RA LT RT	IM	
	DTaP/IPV/HBV/HIB	**Vaxelis**	*6 wks thru 4 yrs*	146		LA RA LT RT	IM	
	HAV *adult*	**Hep A**	*19 yrs & up*	52		LA RA	IM	
	HAV *pediatric*	**Hep A**	*12 m thru 18 yr*	83		LA RA LT RT	IM	
	HAV/HBV	**Twinrix**	*18 yrs & up*	104		LA RA	IM	
	HBV *adult*	**Energix**	*20 yrs & up*	43		LA RA	IM	
	HBV *adult*	**Heplisav-B**	*18 yrs & up*	189		LA RA	IM	
	HBV *pediatric*	**Hep B**	*birth thru 19yr*	08		LA RA LT RT	IM	
	Hib PedVax		*under 5 yr**	49		LA RA LT RT	IM	
	HPV9	**Gardasil**	*9 yr thru 45 yr*	165		LA RA	IM	
	FLU- high dose	**Fluad**	*65 yrs & up*	205		LA RA	IM	
	FLU- PF	**FluLaval/Fluarix**	*6 months & up*	150		LA RA LT RT	IM	
	FLU- **317**	**Flucelvax**	*19 yrs & up*	171		LA RA LT RT	IM	
	IPV		*6 wks & up*	10		LA RA LT RT	IM/SQ	
	MCV4	**Menveo**	*11 yr thru 55 yr*	136		LA RA	IM	
	MMR		*12 m & up*	03		LA RA	SQ	
	MMRV		*4 thru 12 yr*	94		LA RA	SQ	
	PCV-13	**Prevnar13**	*2m thru 4 yr**	133		LA RA LT RT	IM	
	PPV23	**Pneumovax**	*2 yr & up*	33		LA RA	IM/SQ	
	Rotavirus		*up to 8 m, 0 day*	116		PO		
	RZV	**Shingrix**	*50 yrs & up*	187		LA RA	IM	
	Td		*7 yr & up*	113		LA RA	IM	
	Tdap		*7 yr & up*	115		LA RA	IM	
	Trumenba	MenB	*16 yr thru 23 yr*	162		LA RA	IM	
	Typhoid		*3 yr & up*	101		LA RA	IM	
	VAR	**Varicella**	*12 m & up*	21		LA RA	SQ	
	COVID Pfizer 217. Ped 218. Moderna 207. J&J 212					LA RA	IM	

HAV/HBV	0, 1, 6 mos. Accelerated 0, 7, 21 – 30 days, 12 mos	**Men B**	**Bexsero** 0, 1 mo. **Trumenba** 0, 6 mos
HBV	**Energix** 0, 1 – 2 and 6 – 18 mos **Heplisav** 0, 1 mo	**RZV**	0, 2 – 6 mos
HPV	start 9 – 14 yrs: 0, 6 – 12 mos / Start 15 yrs + 0, 1 – 2, 6 mos	**VAR**	*Catch-up* 7 – 12 yrs: 3 mos. Age 13 yrs +: 4 weeks

Vaccine Administrator ____________________________ Date given_________________ Revised 2/3/2022

Amt Paid	Cash Credit card	Check #	Transact RX	Pmt Posted	Next Appt Yes No	IMM widget	Note/ESB	ESB √