FDHU FLU/COVID REGISTRATION & CONSENT

☐ **FLU:** ☐ Private Vaccine ☐ VFC Vaccine ☐Adult 317 Flu ☐ **COVID PFIZER MODERNA NOVAVAX**

PLEASE PRINT. Use full, legal name.

FIRST NAME_____ **M.I.** _____ **LAST NAME**_____

DATE OF BIRTH _____ **AGE**_____ **M**_____ **F**_____ **PHONE**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

GENDER Female Male **RACE** *Circle all that apply* White American Indian African American Alaska Native Asian Hispanic/Latino Pacific Islander Other Unknown

Insurance

☐ **Medicaid: Medicaid number** _____

☐ **Medicare Part B: Medicare number** _____

☐ **Tricare: Tricare number** _____

☐ **Private Insurance Co**_____ **Policy #:**_____**Group #**_____

☐ **No insurance** ☐ **Attached copy of 2nd insurance, if applicable**

☐ **Approved to Bill Employer: Employer Name**_____

ANSWER HEALTH QUESTIONS

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), or asthma? Do not include high Blood Pressure.

Y____N____ Do you use tobacco?

----------ADDITIONAL QUESTIONS FOR COVID VACCINE----------

Y____N____ Have you received a dose of COVID vaccine?

Y____N____ Have you tested positive for COVID in the past 90 days?

Y____N____ Have you had a blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia, or Multisystem Inflammatory Syndrome?

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____Have you ever had a **severe** allergic reaction (anaphylaxis) to anything? **List**:_____

I have viewed the Vaccine Information Statement at www.immunize.org or requested a hard copy by calling First District Health Unit at 701-852-1376. I have read the information about the vaccine(s). **I consent for immunizations 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:** _____

FOR FDHU STAFF USE ONLY

Vaccine	CVX	Lot #	Site	Ages	Vaccine	CVX	Lot #	Site
Syringe	150		LA RA LT RT	6 months & up	PPV23	33		LA RA
Fluad	205		LA RA	65 years & up	PCV20	216		LA RA
Adult 317 Flu	171		LA RA	19 years & up				LA RA
COVID			LA RA	**Dose: 1 2 3 (Primary series) 4 ALL Boosters**				

Nurse Initials	Date Given	Documented	Demo/linked	Amt Paid	Pmt Post'd	ESB √	Revised 8/23/2022