First District Health Unit

FDHU School Flu Shot Registration

Register online at www.FDHU.org
-OR-
Complete this form and return to the **school** ASAP

For clinic dates go to **FDHU.org**

PLEASE PRINT neatly in ink. Use full, legal name of person receiving vaccine.

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

DATE OF BIRTH _____ **AGE**_____ **M**____ **F**____ **PHONE** daytime_____☐ **CELL**

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

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

Student's: Parent Name_____ Email:_____

School Name_____ Grade____ Elementary Teacher_____

Answer health questions for person getting flu vaccination

Y____N____ Had a serious reaction from a previous flu vaccination?

Y____N____ Had a severe allergic reaction (anaphylaxis) to any component of the vaccine including egg protein?
List severe allergy and type of reaction: _____

Y____N____ Had Guillain-Barré Syndrome, a temporary severe muscle weakness?

Insurance

☐ **Medicaid: Medicaid number** _____

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

☐ **Tricare: Tricare number** _____

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

☐ **No insurance** (Under 18 years will be billed $20.90) ☐ **Attached copy of 2nd insurance, if applicable**

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.** School-age children at school flu clinics will only be given influenza vaccine. 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

Lot #	Site RA LA	☐ Private Vaccine ☐ VFC Vaccine Student/Staff feeling well today? Yes No Child is 8 years old or younger. Child needs a 2nd dose of flu vaccine. Yes No

Nurse Initials	Date Given	Demo/linked	Amt Paid	Pmt Post'd	ESB ✓	Revised 8/1/2022