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 use 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: Medicaid number** ____

☐ **Tricare: Tricare number** ____

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

☐ **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.		
Feel sick today?	☐ Yes	☐ No
List allergies to medications, food, or latex.	☐ Yes	☐ No
Ever had a life-threatening reaction to a vaccine in the past?	☐ Yes	☐ No
Have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or spinal fluid leak?	☐ Yes	☐ No
On long-term aspirin therapy?	☐ Yes	☐ No
Had a seizure or had a parent or sibling who has had a seizure? Had brain or other nervous system problems, or Guillain-Barré (a paralyzing polio)?	☐ Yes	☐ No
Have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have a parent or sibling with congenital or hereditary immunodeficiency?	☐ Yes	☐ No
In the past 6 months, taken medications affecting 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, received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐ Yes	☐ No
Had vaccinations in the past 4 weeks?	☐ Yes	☐ No
Use Tobacco or e-cigarettes?	☐ Yes	☐ No
Ever felt dizzy or faint before, during or after a shot? Anxious about getting a shot?		
Females only: pregnant or is there a chance she could become pregnant during the next month?	☐ 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. A copy may be requested from First District Health Unit 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. **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

☐ **VFA**: Underinsured/No insurance:
Flu, MMR, & Tdap (19 +). HPV (19 – 45 yrs) MCV4 & COVID (19 – 64 yrs) PCV20 (high risk 19 – 64yrs)
Hep A, Hep B, Twinrix (high risk 19+, not for travel.)

	VACCINE		AGES	CVX	LOT	SITE	Route	INITIAL
	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	
	Men B	**Bexsero**	*16 yr thru 23 yr*	163		LA RA	IM	
	Men B	**Trumenba**	*16 yr thru 23 yr*	162		LA RA	IM	
	MMR		*12 m & up*	03		LA RA	SQ	
	MMRV		*4 thru 12 yr*	94		LA RA	SQ	
	PCV13	**Prevnar 13**	*2m thru 4 yr**	133		LA RA LT RT	IM	
	PCV20	**Prevnar 20**	*19 yrs & older*	216		LA RA	IM	
	PPV23	**Pneumovax**	*2 yr & up*	33		LA RA	IM/SQ	
	Rotavirus		*up to 8 m, 0 day*	116		PO		
	RSV – resp virus	**Arexvy**	*60 yrs & up*	303		LA RA	IM	
	Td		*7 yr & up*	113		LA RA	IM	
	Tdap		*7 yr & up*	115		LA RA	IM	
	Typhoid		*3 yr & up*	101		LA RA	IM	
	VAR	**Varicella**	*12 m & up*	21		LA RA	SQ	
	Zoster-RZV	**Shingrix**	*50 yrs & up*	187		LA RA	IM	
	COVID **308**: 6m – yrs **310**: 5 – 11 yrs **309**: 12yrs+					LA RA	IM	ml

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

Amt Paid	Transact RX	Pmt Posted	Nurse Initials	Date Given	Documented	ESB √	Revised
							11/9/2023