☐**Consent Completed on-line** **First District Health Unit 2024-2025**

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

DATE OF BIRTH _____ **AGE**_____ **GENDER:** Female Male **PHONE**_____

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

RACE: To better serve our population, circle ALL that apply: Caucasian American Indian African American Alaska Native Asian Hispanic/Latino Pacific Islander Other:_____ Unknown Prefer not to answer

How did you hear about the clinic?

☐ Newspaper ☐ Radio ☐ Facebook ☐ Billboard ☐ Friend/Relative ☐ Website ☐ Flyer ☐_____

What vaccine do you want today? ☐ FLU ☐COVID ☐Tdap (Tetanus, diphtheria, pertussis) Need every 10 yrs
☐ PCV20 (Pneumonia) Age 65 plus ☐ RSV (Respiratory Virus) Age 75 plus ☐ SHINGRIX (Shingles) Age 50 plus

ANSWER HEALTH QUESTIONS:

Y____N____ Do you feel sick today?

Y____N____ Had a serious reaction from any previous vaccines?

Y____N____ Had a severe allergic reaction (anaphylaxis) to any vaccine?

Y____N____ Have you had Guillain-Barré Syndrome, a temporary severe muscle weakness?

Y____N____ Do you have a long-term health problem with lungs (COPD, asthma), heart (Not high blood pressure), kidneys, liver, diabetes, or blood disorders? (Recommend: PCV20 19 – 64 yrs)*

Y____N____ Do you use tobacco? (Recommend: PCV20 for 19 – 64 years)*

COVID QUESTIONS:

Y____N____ Have you had myocarditis/pericarditis within 3 weeks of a COVID vaccination, or history of Multisystem Inflammatory Syndrome (MIS)?

Y____N____ Have you had COVID virus in the last 3 months?

Y____N____ Have you had COVID vaccine in the last 2 months?

Vaccine Information Statements are available to read at www.immunize.org/vis/ or a hard copy can be requested. 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 on 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.

FDHU STAFF USE ONLY **VFC**: thru 18 yrs ☐Medicaid ☐AI ☐No ins ☐Under ins **VFA:** 19 yrs + State program eligibility
☐Private FLU ☐ **VFC/VFA FLU (collect $0 - $20.90)** ☐Private COVID ☐VFC/VFA COVID (collect $0)
☐PCV20 ☐RSV ☐SHINGRIX ☐ Tdap no latex/vial **Unstable progressive neurologic problem is precaution for Tdap.**

First District Health Unit

Vaccine	CVX	CPT	Lot #	Site
Flu syringe 6mo +	140	90656		LA RA LT RT
Fluad 65 yrs +	168	90653		LA RA
VFA Flu 19 yrs +	153	90661		LA RA
PVC20	216	90677		LA RA
RSV	305	90679		LA RA
Shingrix	187	90750		LA RA
COVID **308:** 6m – 4yrs **310:** 5 – 11yrs **309:** 12yrs +				LA RA LT RT
Tdap	115	90715		LA RA
				LA RA

Nurse Initials	Date given	Documented	Demo/linked	Amt Paid	Pmt Posted	ESB √	Revised 9/12/24

TransactRX Reimbursement Amt	RSV amt:	Shingrix amt:	Tdap amt:
	Flu amt:	PCV amt:	COVID amt: