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.

SIGNATURE OF CLIENT OR PERSON AUTHORIZED TO CONSENT ON THE CLIENT'S BEHALF TO RECEIVE VACCINATION:

X_____ **DATE:**_____

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

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: