Greetings!
My name is Joan Connell. I am a pediatrician from Bismarck UND Center for Family Medicine. I am excited to partner with Dr. Peter Sandroni and the Family Medicine residents from Minot UND Center for Family Medicine and the FDHU McHenry County Public Health team to offer your middle and high school student(s) ***FREE*** well child/adolescent checks at the TGU Towner School on Thursday, June 19, 2025.

During these well checks, we will listen to concerns you/your child have, ask questions about general health issues (sleeping, exercise, diet, mental health, dental care, etc.) as well as perform physical exams and some screening tests (vision check, anxiety/depression screens). We will discuss our findings with your child, as well as any recommendations if we find something that needs to be evaluated more closely or treated. We will also discuss healthy lifestyle topics.

If interested, we will provide sports physicals/clearances for those interested in participating in sports during the 2025-26 school year. Finally, we will be able to provide immunizations to your child if any are needed.

For your child to participate in this well child check, we will need your child to return the following paperwork that has been completed:

- **Consent form - signed by parent/guardian-please indicate if you would like immunizations, sports physicals, fluoride by checking the appropriate boxes.** Please make sure your **phone number is listed** so we may call you to schedule the time of your well check/sports exam on June 19.
- **NDHSAA History form-** please complete this **ONLY if you would like your child to have a sports physical**. It must be signed by the parent/guardian and the athlete.
- **Sharing Health Record form- signed by parent/guardian**
- **Initial History Questionnaire (2pages)**
- **Fluoride varnish consent form** – please complete this **ONLY if you would like your child** to have fluoride.
- **Vaccine consent form** – please complete this **ONLY if you would like your child to receive** immunizations. Please include insurance information on that form.

<u>The paperwork packet must be returned to the school office OR to Nancy Bryn at the FDHU McHenry County office in Towner. (Phone 701-537-5732).</u>

Call Nancy at the Towner office at 701-537-5732 to schedule your child!

Please note that all forms must be completed/signed and returned for your child to receive care.
Thank you so much for your time and attention. I look forward to providing this well service for your child!

Joan Connell, MD MPH
Pediatrician
UND Center for Family Medicine
Bismarck, ND 58501- 701-751-9500

Date: _____

I _____ have read and fully agree to each of the statements in this form and sign below as my free and voluntary act. UND CFM will not be bound by any changes I make to this document. I have been given the opportunity to have my questions answered about this form and the UND CFM Notice of Privacy Practices. Except for services that I receive on an emergency basis, I understand that if I refuse to sign this document as presented, UND CFM may not be able to provide services to me.

Patient Name:_____ Patient's Date of Birth:_____

_____

Signature of patient or legally authorized representative to patient

_____

Printed Name of legally authorized representative to patient

Relationship to patient: Self Parent Guardian Other:_____

Additional Services Options – please check all that apply:

Vaccinations

- ☐ Meningitis ACWY
- ☐ Meningitis B
- ☐ Tdap
- ☐ HPV
- ☐ I decline all immunizations

Sports Physicals

- ☐ I would like a sports physical for the 2025-26 academic year
  *Checking this box will require you to complete, sign and return the 2-page NDHSAA sports history form
- ☐ I do not want a sports physical

Fluoride Varnish

- ☐ I would like fluoride varnish for my child's teeth.
  *Checking this box will require you to complete, sign and return the Fluoride Varnish Consent Form
- ☐ I do not want Fluoride Varnish

Name: (First, Middle, Last)_____

Date of Birth: ____/_____/_____ Gender: (circle one) Female Male

Race: White American Indian Alaska Native Asian Black or African American Pacific Islander Other:_____

Hispanic or Latino (circle one): Yes No

Mailing Address: _____

City, State, Zip: _____

Telephone Number: _____ (parent's number to be able to reach on screening day)

This document applies to individuals receiving care from the UND Center for Family Medicine-Bismarck ("UND CFM").

General Consents and Acknowledgements

A **Consent for Diagnosis, Care and Treatment.** I consent to diagnosis, care and treatment that I have agreed to receive and that is considered necessary or advisable by my physicians(s), including my attending physician and other healthcare professionals who may be involved in my care and at UND CFM, their employees and agents. I acknowledge that no guarantees have been made to me about the result of my examination or treatment at or by any UND CFM employees. If I am pregnant, I agree that all the provisions in this General Consent also apply to my newborn child/children for their care and treatment while at UND CFM after birth.

B **Right to Refuse Treatment.** In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by UND CFM Physician(s).

C **Medical Education and Participation of Students and Trainees.** I understand that my care will be provided in a teaching environment and that physicians, nurses, and other health care professionals in training may be involved in my care and treatment.

D **Personal Property.** I understand that the UND CFM will not be responsible for the loss, destruction or theft of any personal property that I bring with me to the clinic.

E. **Communications Consent:** By providing my cell, landline, or any other number(s), I expressly consent to receiving communications from clinic, its staff, its contractors, collection agents, and others, at any numbers I provide or that are later acquired for me. These parties may use this information to contact me by live agent, voice mail, text message, using an auto dialer or other computer assisted technology, pre-recorded message(s), or by any other form of electronic communication for any purpose including, but not limited to, appointment and follow-up health care reminders, scheduling, my account(s), assignment of benefits, and/or financial responsibility. I understand that depending on my phone plan I could be charged for these calls or text messages. I agree to provide new number(s) if my number(s) change. Providing these numbers is not a condition of receiving health care services.

F **Appointment Reminder.** I am aware that my scheduled appointment will receive an automated appointment reminder at the preferred listed phone number in my UND CFM account. The reminder will include location, date, and time of the appointment. If I do not wish to receive a reminder call or prefer a different preferred phone number, I will alert the UND CFM staff.

Health Information

I understand that my UND CFM medical record and other information related to my diagnosis, care and treatment (referred to a "my health information") may be in electronic, video, photographic, audio and other forms. I consent to production and internal use by UND CFM of any videotape, photographs, audio records and other images containing my health information for education and for healthcare operations as defined in the UND CFM Notice of Privacy Practices.

A. **Treatment and Continuity of Care.** As applicable, and when my consent is required by law, I consent to UND CFM contacting or sharing my health information with other healthcare providers, such as independent Physicians, physicians not on staff at UND CFM, other hospitals, nursing homes, home health agencies, and pharmacies, to obtain information about my prior and current health conditions for treatment at a UND CFM or as necessary for treatment, continuity of care and discharge planning purposes.

B **Mental Health/Developmental Disabilities/Alcohol and Drug Abuse/HIV/AIDS/GENETIC Testing and Counseling.** As applicable, and when my consent is required by law, a RELEASE OF INFORMATION will need to be signed relating to records of my treatment for mental health and developmental disabilities, alcohol and drug abuse, HIV, AIDS, and genetic testing and counseling ("sensitive health information") as defined in the UND CFM Notice of Privacy Practices.

NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s) _____

Sex _____ Age _____ Grade _____ School _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). _____

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). _____

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic poly- morphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

NDHSAA Board Approval: September 2019

NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had, or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

NDHSAA Board Approval: September 2019

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of Birth_____

1. Date of disability:	
2. Classification (if available):	
3. Cause of disability (birth, disease, injury or other):	
4. List the sports you are playing:	

	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "Yes" answers here.

_____

_____

Please indicate whether you have ever had any of the following conditions:

	Yes	No
Atlantoaxial instability		
Radiographic (x-ray) evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "Yes" answers here.

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____ Date: _____

NDHSAA Board Approval: September 2019

Sharing of Your Health Record

Your health data is stored in an electronic medical record known as One Chart. One Chart is used by this health care provider and others we have a direct relationship with. This form explains how your health record in One Chart is shared with friends, family and other unrelated health care providers. This is called disclosure and happens for:

Friends and Family

Privacy laws allow verbal (spoken) health data to be shared with family and close personal friends. This sharing is allowed when family and friends are directly involved in a patient's care or payment for care. Please ask staff at the reception desk to limit that sharing if you have concerns about family and friends getting your health data. Family and friends may not receive copies of your records without your consent.

Payers for Payment

Privacy laws allow health data related to services received to be shared for payment. This means your health record may be shared with your health insurance company or other sources that help pay your bill.

- I agree to tell my health care provider when I arrive if I do not want records from that visit to be shared for payment. I understand that payment must be made by me alone.

From Payers and Networks

Your health insurance company may want to share your health data with us to improve the quality of your care. This may include your records from past, current and future treatment at other health care providers.

- I agree that my health insurance company including accountable care organizations may share my health and account records from any other sources with my current care provider.

Health Care Providers for Treatment

Health data can be shared between health care providers to help with your care, especially in an emergency.

- I consent to share my health record with other health care organizations directly involved in my current or future treatment. This sharing may occur on paper or by electronic means. This sharing includes regional or national health information exchanges (health care provider groups). This consent does not include sharing of records by or from a drug or alcohol abuse treatment program unless I have given that program written consent.

This consent will be forever unless you stop it by writing our medical records department. Stopping this consent will not change releases that have already been made.

Relationship to Patient:

_____ I am the Patient _____ I am the Parent/Guardian _____ I am the POA

_____ _____

Signature of Patient or Legal Representative Date/Time

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY

DATE COMPLETED

BIRTH DATE

AGE

☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ■ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

HE0328

9-223/0109

Fluoride Varnish Consent Form

A licensed health professional will be applying fluoride varnish to your teeth as a means of preventing tooth decay (cavities).

Fluoride varnish is a protective coating that is painted on teeth. The varnish releases fluoride over a period of time, which strengthens teeth and prevents tooth decay. Tooth decay is the most common chronic disease found in children.

___ YES, I would like my child/myself to receive the fluoride varnish application.

___ NO, I do not wish for my child/myself to receive the fluoride varnish application.

Does the person receiving fluoride varnish see a dentist at least once per year? ___ YES ___ NO

If Yes, name of dentist: _____ Last visit: _____

_____ _____

Signature of Parent/Caregiver/Self Date

_____ _____

Please print name of Parent/Caregiver/Self Date

Please print. Use full, legal name of person receiving fluoride varnish.

First:_____ Middle Initial:_____ Last: _____

VACCINE CONSENT

First District Health Unit

Information is for the person receiving the vaccine. Please print. Use full legal name.

First Name: _____ MI: ___ Last: _____ Date of Birth: _____

Mailing Address: _____ Telephone: _____

Age: _____ Gender: F or M Email: _____ **Preferred language:** English or Other:_____

Race: To better serve our population, circle all that apply: White American Indian Asian Black or African American Alaskan Native Hispanic/Latino Pacific Islander Other_____ Unknown Prefer not to answer

Insurance Company: _____ Policy #: _____ Group #: _____

Secondary Insurance Co: _____ Policy #: _____ Group #: _____

Medicaid Number: _____ ☐ No insurance (Under 18 will be billed $20.90 per dose)

Health Questions for the person who is receiving vaccines or a blood draw:		
Has the person eaten today?	☐ Yes	☐ No
Ever felt dizzy or faint before, during or after a shot or a blood draw? Feel anxious today?	☐ Yes	☐ No
Feel sick today?	☐ Yes	☐ No
List allergies to medications, food, or latex.	☐ Yes	☐ No
Have a long-term health problem with lung, heart, kidney, liver, brain/nervous system, metabolic disease (e.g., diabetes), asthma, blood disorder, no spleen, a cochlear implant, or spinal fluid leak?	☐ Yes	☐ No

Additional Health Questions for the person receiving vaccines:		
Ever had a life-threatening reaction to a vaccine in the past?	☐ Yes	☐ No
On long-term aspirin therapy?	☐ Yes	☐ No
Had a seizure or had a parent, brother or sister who has had a seizure? Any brain or other nervous system problems?	☐ Yes	☐ No
Have cancer, leukemia, HIV/AIDS, or any immune system problem? Have a parent, brother, or sister with an immune system problem?	☐ 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 immune (gamma) globulin or an antiviral drug?	☐ Yes	☐ No
Been diagnosed with a heart condition (myocarditis/pericarditis), or had a history of Multisystem Inflammatory Syndrome (MIS-C) after an infection with COVID virus?	☐ Yes	☐ No
Had vaccinations in the past 4 weeks?	☐ Yes	☐ No
Uses Tobacco or e-cigarettes?	☐ Yes	☐ No
Females only: pregnant or could become pregnant during the next month?	☐ Yes	☐ No
Babies only (under 8 months): had intussusception (bowel obstruction)?	☐ Yes	☐ No

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:**_____