First District Health Unit
www.fdhu.org

FDHU will be giving flu vaccine at the schools this fall.
The flu shot will be the only form of vaccine available.

To receive a flu vaccination, complete consent and return to the **school ASAP**

For dates of clinics please check our website fdhu.org

If you do NOT want your child to receive flu vaccine, do NOT fill out or return form

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_____

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____ Allergic to latex, food, or medicine? **List allergies:**_____

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

BCBS, Sanford, Tricare, United Healthcare, Medica, Meritain and Preferred One are network insurances. (NOT Sanford True.) **You will be billed $52 if your insurance denies the claim or the form is turned in with incomplete insurance information.**

☐ **MEDICAID OR MEDICARE NUMBER:** _____

☐ **INSURANCE COMPANY:** _____ Payer ID / EDI #:_____ back of card

Policy Holder: Name (First MI Last): _____ Date of Birth: _____

Gender: Male / Female Relationship to client: _____ Group #_____

Policy Holder ID #*:_____ Client ID # (if different): _____

Tricare** use 11 digit **Benefits Number** on ***back of card: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ **Do not have 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 viewed a hard copy by calling First District Health Unit at 701-852-1376. I have read the information about the vaccine(s). I had an opportunity to ask questions and believe that I understand the benefits and risks of the vaccine(s). **I consent to the administration of the vaccines listed to be given to the person named above & am authorized to give consent.** 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

Vaccine Administrator Initials					Date given				
Amt Paid	Cash Credit Card	Check #	Transact RX	Pmt Post'd	Demo	IMM widget	Note done/sent	ESB ✓	Revised 08/13/20