Online registration available

FDHU School Flu Shot Consent

This form is <u>not needed if</u> online registration has been completed.

Clinic dates at **FDHU.org**

First District Health Unit
www.fdhu.org

PLEASE PRINT neatly in ink. Use full, <u>legal</u> 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_____ Email:_____

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

List severe allergy and type of reaction: _____

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

Insurance

☐ **Medicaid: Medicaid number** _____

☐ **Medicare Part B: Medicare number** _____

☐ **Tricare: Tricare number** _____

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

☐ **Private Insurance Co #2**_____ **Policy #:**_____ **Group #**_____

☐ **No insurance** (Under 19 years will be billed $20.90) Financial assistance is available

I have viewed the Vaccine Information Statement at https://www.immunize.org/vaccines/vis/influenza-inactivated/ or requested a hard copy by calling First District Health Unit at 701-852-1376. I have read the information about the vaccine(s). **<u>I consent for immunizations to be given to the person named above</u> & am authorized to give consent.** School-age children at school flu clinics will only be given influenza vaccine. 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 <u>TO CONSENT</u> ON THE CLIENT'S BEHALF TO <u>RECEIVE</u> VACCINATION:

X_____ **DATE:**_____

FOR FDHU STAFF USE ONLY

Lot #	Site RA LA	☐ Private Vaccine ☐ VFC Vaccine Student/Staff feeling well today? Yes No				
Nurse Initials	Date Given	Demo/linked	Amt Paid	Pmt Post'd	ESB ✓	Revised 7/2025