



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

For dates of clinics  
please check our  
website  
fdhu.org

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

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 2<sup>nd</sup> insurance, if applicable**

I have viewed the Vaccine Information Statement at [www.immunize.org](http://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	<input type="checkbox"/> Private Vaccine <input type="checkbox"/> 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 <input checked="" type="checkbox"/>	Revised 08/13/20