FLU IMMUNIZATION VAR
SOUTHWESTERN DISTRICT HEALTH UNIT
227 16TH STREET WEST, DICKINSON, ND 58601

Public Health

Client's Last Name _____ Client's Legal First Name _____ M.I. _____ Other / Maiden Name _____ M F Gender (circle)

Client's Date of Birth _____ Client's Age _____ Client's Birth State _____ Mother's Name (if under 18) _____

Address (Street or PO Box) _____ City _____ State _____ Zip _____

Home Phone Number _____ Cell Phone Number _____ Work Phone Number _____ Primary Care Provider _____

Person Financially Responsible for Client _____ Relationship to Client _____ Address if different from Client's address _____

***Tobacco Use:**
- ☐ Current
- ☐ Former
- ☐ Never

Secondhand Smoke:
- ☐ Exposed
- ☐ Not Exposed

Advised to Quit:
- ☐ Yes
- ☐ No
- ☐ NA

Referral Offered:
- ☐ Yes
- ☐ No

Referral Accepted:
- ☐ Yes
- ☐ No

Race:
- ☐ White
- ☐ Black
- ☐ American Indian
- ☐ Asian
- ☐ Native Hawaiian

Ethnicity:
- ☐ Not Hispanic
- ☐ Hispanic

Language Preferred:
- ☐ English
- ☐ Spanish
- ☐ Other: _____

VFC Eligibility Status (check all that apply):
- ☐ ND Medicaid
- ☐ American Indian
- ☐ No Insurance
- ☐ Underinsured
- ☐ Not Eligible - (Vaccines covered by Health Insurance, Adult, etc.)

Do you have private insurance that covers immunizations? ☐ **Yes** ☐ **No**

Primary Insurance Provider:
- ☐ Blue Cross Blue Shield **State** _____
- ☐ Sanford Health Plan
- ☐ Sanford Medicaid Expansion
- ☐ ND Medicaid #_____
- ☐ Medicare #_____
- ☐ RR Medicare # _____
- ☐ Other: _____

Insurance Policy Number: _____

Insurance Policy Subscriber's Name: _____

Subscriber's Date of Birth: _____

Relationship to Client:
☐ Self ☐ Parent ☐ Spouse Other: _____

Subscriber's Address (if different than client's) _____

I acknowledge that I have been provided with Southwestern District Health Unit's Notice of Privacy Practices. I understand that I may request an additional copy of this Notice. I agree that I am financially responsible for services provided and not covered by a third-party payer. I assign and authorize any third-party payer to make payment to SWDHU for all benefits that I am eligible for.

I authorize the release of any medical or other information necessary to process this claim.

The information collected on this form will be used to document authorization to receive vaccinations. Information may be shared through the ND Immunization Information System (NDIIS) with other entities in accordance with ND Century Code 23-01-05.3. A copy of the appropriate Center's for Disease Control & Prevention Vaccine Information Statement(s) has been provided. I have read, or have had explained, the information about the disease(s) and the vaccine(s) listed. I had an opportunity to ask questions which were answered satisfactorily. I understand the benefits and risks of these vaccine(s) and ask that the vaccine(s) listed be given to me or the person named above for whom I am authorized to make this request.

Signature of Client / Parent or Legal Guardian (if under 18) _____ Date _____

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Clients' Name: _____

Please answer questions below	Circle One			Comments
Is the person to be vaccinated sick today?	Yes	No	Unknown	
Does the person to be vaccinated, have an allergy to chicken eggs, thimerosal, latex, or a past flu immunization?	Yes	No	Unknown	
Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	Yes	No	Unknown	
Has the person to be vaccinated ever had Guillain-Barre Syndrome?	Yes	No	Unknown	

If you are 65 or older please answer question below also	Circle One			Comments
Have you received a pneumonia vaccine in the past?	Yes	No	Unknown	

OFFICE USE ONLY - FLU

Private

✓	Vaccine	Code	Price	VIS	MFR	Lot #	Rt	Admin	Nurse Signature	Date
	Influenza (6 thru 35 months)	Z23 90685	$45.00	8/7/2015	SP	UT5913LA 6/30/2018	IM	LA RA LT RT		
	Influenza (age 3 thru adult)	Z23 90686	$45.00	8/7/2015	GSK	9BK4X 6/30/2018	IM	LA RA LT RT		

Private - Other

	Influenza (6 thru 35 months)	Z23 90685	$45.00	8/7/2015	SP		IM	LA RA LT RT		
	Influenza (age 3 thru adult)	Z23 90686	$45.00	8/7/2015	GSK		IM	LA RA LT RT		

State

✓	Vaccine	Code	Price	VIS	MFR	Lot #	Rt	Admin	Nurse Signature	Date
	Influenza (6 thru 35 months)	Z23 90685	$20.99	8/7/2015	SP	UT5897KA 6/30/2018	IM	LA RA LT RT		
	Influenza (age 3 thru 18)	Z23 90686	$20.99	8/7/2015	GSK	9M3F7 5/30/2018	IM	LA RA LT RT		
	Influenza (age 3 thru 18)	Z23 90686	$20.99	8/7/2015	GSK	2GM7P 5/28/2018	IM	LA RA LT RT		

State - Other

	Influenza (6 thru 35 months)	Z23 90685	$20.99	8/7/2015	GSK		IM	LA RA LT RT		
	Influenza (age 3 thru 18)	Z23 90686	$20.99	8/7/2015	GSK		IM	LA RA LT RT		

OFFICE USE ONLY - PNEUMOCOCCAL

✓	Vaccine	Code	Price	VIS	MFR	Lot #	Rt	Admin	Nurse Signature	Date
	PCV-13	Z23 90670	$254.00	11/5/2015	WAL		IM	LA RA LT RT		
	PPV-23	Z23 90732	$146.00	4/24/2015	MSD		IM	LA RA LT RT		

Total Charges:	Amount Paid:	✓	Payment Type			Staff Initials
			Cash			
			Check	Check #		
			Credit Card	Transaction #		
			Superbill given			

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