FLU CONSENT 2021-2022 Pediatric/Adolescent (6 mo. – 18 yrs)
Dickinson-Iron District Health Department □ Checked by clerk

Patient's Name: _____ **Birth Date**: _____
Last First Middle

AGE: _____

Vaccine For Children (VFC) Screening Tool Check all that apply to your child or dependent

□ Child is enrolled on Medicaid (VFC Vaccine)
□ Child is a Native American or Alaskan Native (VFC Vaccine)
□ Child has no health insurance (VFC Vaccine)
□ Child has health insurance, but it does not cover any portion of this immunization (VFC Vaccine)
□ Child has health insurance, please bill insurance for this service. (Private/Insurance Vaccine)
Be sure to complete insurance section on back!

	Circle answers
Is the patient sick today?	YES NO
Is the patient allergic to eggs?	YES NO
Has the patient had a serious reaction to a previous dose of influenza vaccine?	YES NO
Does the patient have any other serious allergies? Please list:	YES NO
Has the patient ever had Guillain-Barre' Syndrome? (type of temporary severe muscle weakness)	YES NO

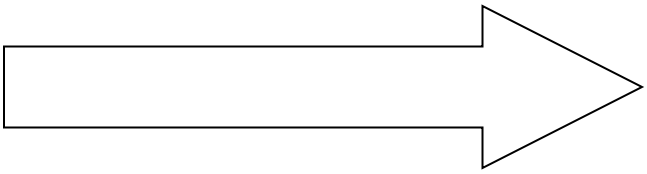
"I have read or have had explained to me information about the influenza vaccine as in the attached vaccine information sheet. I have completed the questions on the back side of this consent. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named for whom I am authorized to make this request."

"I authorize the Dickinson-Iron District Health Department, DIDHD, to release all necessary information and records for the billing and receiving payment for services received. I authorize and assign directly to the DIDHD any and all benefits I may be entitled to and are otherwise payable to me for these services. After payment is received from my insurance company, I understand I may be responsible for any balance on my account for which I will receive a statement. If however, I personally receive payment from my insurance company for these services, I will forward this payment to the DIDHD."

"I acknowledge that I have received a copy of the DIDHD's Notice of Privacy Practices."

_____ _____
Parent or Guardian's Signature **Date Shot Received**
Patient's Signature (if 18 or older)

Everyone, please complete Back Side of Form



Patient: Name _____ Last First MI			Date of Birth:
Mailing Address:			□ Male □ Female
City:	St:	Zip:	Phone:

Only complete this section if this service is being billed to private health insurance

Name of Insurance Company:
Group Number:
Insurance Billing Address: Ins. Phone #:
Contract/Policy/ID#:
Subscribers Information (Policy Holder of Insurance)
Subscriber's Employer**:**
Subscriber's Relationship to Patient:
□ Self - **If Self, stop here**
□ Spouse □ Child □ Other **(Provide subscriber information below, if not self)**
Last Name: First: Middle Initial:
Date of Birth:
Sex: □ Male □ Female
Is subscriber's address same as patient's? □ Yes □ No, if no complete address below.
Address (Street): City: State: Zip:
Phone:

OFFICE USE ONLY

□ **Bill Insurance**	**Private Vaccine**	
□ **Bill Medicaid**	**VFC Vaccine**	**ID #** _____ Health Plan (circle plan): UPHP FFS
□ **Self Pay:**	**VFC Vaccine**	***$15*** ***Cash***____ ***Check #*** __**__** ***Cashier's Initials:*** _____

□ **Check this box if nurse entered the administration directly into ECW. Otherwise document the administration below.**

Vaccine Information: Manufacturer: _____ Exp. Date: _____ Lot #: _____

Administration Site: L-Arm R-Arm L-Leg R-Leg

Signature/Title of Administrator: _____ RN or LPN **Date Administered**: _____