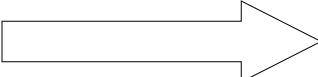
FLU CONSENT 2023-2024 Pediatric/ Dickinson-Iron District Health Departmen			ecked by clerk						
Patient's Name:	First	Middle	_ Birth Date: _						
Vaccine For Children (VFC) Screening To	ol Check a	all that apply to your chil	d or dependent						
 □ Child is enrolled on Medicaid (VFC Vaccinum Child is a Native American or Alaskan Natinum Child has no health insurance (VFC Vaccinum Child has health insurance, but it does notup Child has health insurance, please bill insurance section on the sure to complete insurance section on the child has health insurance section on the sure to complete insurance section on the child has health insurance section on the sure to complete insurance section on the child has health insurance section on the sure to complete insurance section on the child has health insurance section on the sure to complete insurance section on the child has health insurance section on the sure to complete insu	ve (VFC Vacc ne) cover any por rance for this	tion of this immunization	•	e)					
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	ous dose of influ	enza vaccine?		YES	NO				
Does the patient have any other serious allergies	? Please list:			YES	NO				
Has the patient ever had Guillain-Barre' Syndrom	e? (type of tem	porary severe muscle we	eakness)	YES	NO				
"I have read or have had explained to me information about the questions on the back side of this consent. I have had a char benefits and risks of influenza vaccine and ask that the vaccine." I authorize the Dickinson-Iron District Health Department, DII for services received. I authorize and assign directly to the Diservices. After payment is received from my insurance compareceive a statement. If however, I personally receive payment. I acknowledge that I have received a copy of the DIDHD's Not	nce to ask questions ne be given to me o DHD, to release all IDHD any and all be any, I understand I t from my insurance	s that were answered to my sa r to the person named for who necessary information and rec enefits I may be entitled to and may be responsible for any ba e company for these services,	tisfaction. I believe I um I am authorized to report or the billing and I are otherwise payablelance on my account for the street of the street or the stree	understand make this I receiving e to me fo for which I	d the request." g payment or these will				
Parent or Guardian's Signature Patient's Signature (if 18 or older)	-	Date S	hot Received						
Everyone, please complete Back Side of Form									



Patient:				Date of	Date of Birth:		
Mailing Address:			First	MI	B.A1		Ганта
Mailing Address.					□ Male	<u> </u>	Female
City:			St:	Zip:	Phone:		
Only comp	olete this sec	tion if the	is service is	being bille	ed to private h	ealth ins	urance
Name of Insuran	ce Company:						
Group Number:							
Insurance Billing A	Address:				Ins. Phone	e #:	
Contract/Policy/ID							
Subscribers Info		v Holder	of Insurance)				
Subscriber's Empl	•						
Subscriber's Relat		ent:					
□ Self - If Self, s	•						
	hild D	her	(Provide su	nscriber info	ormation below	if not se	ılf)
Last Name:		. 101	First:		Middle I		··· <i>)</i>
Date of Birth:			1 1100.		WIIGGE I	i iitidi.	
	□ Female						
			541-0 V	NI			
ls subscriber's	address san	ie as pati			o, if no comple		
Address (Street):				City:	State	e:	Zip:
Phone:							
Bill Insurance	Private Vaccin		OFFICE USE	ONLY			
	Private vaccii	ie					
Bill Medicaid	VFC Vaccine] ID#		_ Health Pl	an (circle plan)	: UPHP	FFS
Calf Davis VEC	V:) Cash	Ched	k#	Cashier's Init	ials:	
Self Pay: VFC	Vaccine \$20	00.01					
Self Pay: VFC	vaccine \$20						
Self Pay: VFC	vaccine \$20						
Self Pay: VFC	vaccine \$20						
				ECW. Otherwi	se document the a	ndministrati	on below.
Check this box if nu	rse entered the a	ndministratio	on directly into				
Check this box if nuccine Information: M	rse entered the a	administratio	on directly into		_ Lot #:		