RICHLAND COUNTY INFLUENZA VACCINE CONSENT FORM

413 3rd Ave. North, Wahpeton, ND 58075 Phone: (701) 642-7735, Fax: (701) 642-7746
Tax ID Number: 45-600-2236 NPI Number: 1275626053

Please Print Information about the person receiving vaccine						Richland County Employee ☐
Last Name	First Name	Middle Name	**Ethnicity** of client: (Check only one box) ☐ Hispanic or Latino ☐ Not Hispanic or Latino			
Address (Street or P.O. Box):		City:		State:	Zip Code:	
County:	State of **Birth**:	Gender (Circle) Male Female	Birth date:	Age:	Primary Phone #:	
					Cell Phone #:	

Race: (Check all applicable boxes) ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

Non-Medicare Insurance Information			Medicare Insurance Information
ND Medical Assistance #:			**Medicare Claim #:**
Insurance plan name: ☐ BCBS of _____ (state), ☐ Medica ☐ Sanford			Effective Date Medicare Part A
ID #:	Plan or Group #:		Effective Date Medicare Part B
Policy Holder Name	DOB:	Relationship	**Other Medicare Insurance (Medica or Humana)**
			Plan Name:
Policy Holder Address (if different)			ID #:
			Address

1. Have you been sick in the last two days?..... ☐ Yes ☐ No
   (persons who are sick and have a fever should delay vaccination).
2. Have you had a flu shot before?..... ☐ Yes ☐ No
3. Have you had a severe reaction to the flu shot?..... ☐ Yes ☐ No
4. Do you have a severe allergy to eggs or latex?..... ☐ Yes ☐ No
5. Have you had Guillian Barre?.....☐ Yes ☐ No

MY SIGNATURE BELOW INDICATES:

1. A copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Statement on Influenza has been provided. I have read, or have had explained, information about the disease and vaccine. There was an opportunity to ask questions and all questions were answered satisfactorily. I believe that I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above (for whom I am authorized to make this request.)
2. Information collected on this form will be used to document authorization for receipt of vaccine. Information may be shared through the North Dakota Immunization Information System (NDIIS) with other entities in accordance with the ND Century Code 23-01-05.3.
3. I acknowledge the office of the Richland County Health Department has provided me with their Notice of Privacy Practices.
4. I authorize the release of any medical or other information necessary to process this claim.
5. If I am the client, or an individual legally obligated to pay for medical expenses provided to the client or a Guarantor of payment, I agree to pay and I am financially responsible for Richland County Health Department's established charges provided to the client not covered by a third-party payer.
6. I assign and authorize any third party payer/insurer to make direct payment to Richland County Health Department of all benefits payable for the client's care.

Signature – Person to receive vaccine or person authorized to sign on the client's behalf:	Date:

Agency use: ☐ Data Entry into Champ/Thor ☐ Nurse/Billing Review ☐ Scanned into Champ

NURSING SECTION

VFC (Vaccine For Children 18 or Younger) Eligibility Status (GIVE STATE OR VFC VACCINE)

□ Is American Indian or Alaskan Native
□ Has Medical Assistance/Medicaid
□ Does not have health insurance
□ Underinsured (vaccines not covered by health insurance)

PRIVATE VACCINE (Child or Adult)

□ Not VFC eligible (bill Medica, BCBS, Sanford Health Plan, ND (Adult) Medicaid, Medicare, or Humana)
□ Not VFC eligible – insurances not billed by Richland County Health Department_____
□ Client desires to receive and pay for vaccine and receive a super bill (name of insurance)
□ Client desires to pay for vaccine and declines a super bill

Reported weight (if 18 or younger) _____

Date	Vaccine(s) to be given	VIS Date	MFG.	Lot Number	Exp. Date	Dosage	Admin Site	Route	State or Private
	IIV3 IIV4	08/07/15	SP/GSK			0.25 ml 0.5 ml	LA RA LT RT	IM	S P

Vaccines: IIV3 = Inactivated Influenza Vaccine, Trivalent IIV4 = Inactivated Influenza Vaccine, Quadrivalent
Manufacturer: SP = Sanofi Pasteur (Aventis), GSK = Glaxo Smith Kline
Indicate if state-supplied or privately purchased: S = State-supplied, P = Privately purchased
Site Vaccine Given: RA = Right Arm, LA = Left Arm, RT = Right Thigh, LT = Left Thigh

	Y	N		Y	N
Age between 50-75	□	□	Colonoscopy in last 10 years	□	□
Referred for iFOBT	□	□	Client refused iFOBT	□	□

Nurses Signature: _____ Date:_____

Check #_____ Credit Card Confirmation #_____ Cash_____ Receipt #_____ Initials_____