



Public Health
Prevent. Promote. Protect.
Richland County Health Department

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

Richland County Employee

Information about person to receive vaccine (Please print)							
Name: Last		First		Middle		Ethnicity of client: (Check only one box) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> 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) <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander							

Non-Medicare Insurance Information	Medicare Insurance Information
ND Medical Assistance #:	Medicare Claim #:
Insurance plan name: <input type="checkbox"/> BCBS of _____ (state), <input type="checkbox"/> Medica <input type="checkbox"/> Sanford	Effective Date Medicare Part A
ID #:	Effective Date Medicare Part B
Plan or Group #:	Other Medicare Insurance (Medica or Humana)
Policy Holder Name	Plan Name:
DOB:	ID #:
Relationship	Address
Policy Holder Address (if different)	
Check # _____ Credit Card Confirmation # _____ Cash _____ Receipt # _____ Initials _____	

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 – insurance 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 super bill

Adult:

- Other state eligible or local state eligible (no insurance)

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
	cc IIV4 IIV4 RIV4	08/15/19	SP GSK SEQ PS			0.5 ml 0.7 ml	LA RA LT RT	IM	S P

Vaccines: IIV4 = Inactivated Influenza Vaccine, Quadrivalent , ccIIV4=cell-cultured inactivated influenza vaccine, Quadrivalent

RIV4 = Recombinant Influenza Vaccine Quadrivalent

Manufacturer: SP = Sanofi Pasteur, GSK = Glaxo Smith Kline, PS = Protein Sciences, SEQ = Seqirus

Indicate if state-supplied or privately purchased: S = State-supplied, P = Privately purchased

INTERESTED: Pneumonia Shingrix

Nurses Signature: _____ Date: _____