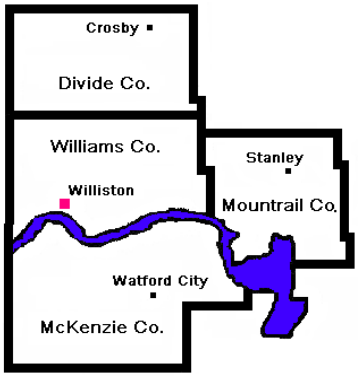
www.umdhu.org



Upper Missouri District Health Unit

"Your Public Health Professionals"

DIVIDE COUNTY
Divide Co. Courthouse
P.O. Box 69
Crosby, ND 58730
Phone 701-965-6813
Fax 701-965-6814

MCKENZIE COUNTY
P.O. Box 1066
201 5th St. NW Suite 1100
Watford City, ND 58854
Phone 701-444-3449
Fax 701-842-6985

MOUNTRAIL COUNTY
Memorial Building
P.O. Box 925
Stanley, ND 58784
Phone 701-628-2951
Fax 701-628-1294

WILLIAMS COUNTY
110 W. Bdwy, Ste 101
Williston, ND 58801-6032
Phone 701-774-6400
Fax 701-577- 8536
Toll Free 1-877-572-3763

Dear Parent/Guardian:

Upper Missouri District Health Unit is happy to be able to provide **Influenza vaccinations** at your child's school this year on Wednesday October 25th. We will be at the grade school from 9am-12pm and at the High school from 1pm-3pm We encourage all children to get vaccinated against Influenza.

Influenza ("flu") is a contagious disease that can be spread by coughing, sneezing, and close contact. Your child is likely to be exposed to this every day in school! A few but not all symptoms of Influenza are shortness of breath, fever/chills, sore throat, muscle aches, fatigue, cough, headache, or runny/stuffy nose.

Payment is determined by the following conditions:

Blue Cross/Blue Shield, Sanford Health, United Health Care, Meritain, Medica or Aetna: *Please provide all your policy information and we will bill directly. If payment applies, you will be billed from UMDHU.*
Medicaid: *We will file with North Dakota Medicaid only. Please provide your Medicaid #.*
Other Insurance (Any Health Insurance other than the ones listed above): *Please send a check, cash, or money order for $65 per flu shot per child with the completed form to the school secretary. We will send the receipt home with your child or mail them. Please file receipt with your insurance company to receive reimbursement.*
No Insurance: *Please send a check, cash, or money order for a recommended payment of $21 per shot per child with the completed form to the school secretary. Checks and money orders can be made out to UMDHU.*

Please review the enclosed information and return the Vaccine Administration Form to your school's secretaries by the day of the vaccine clinic. Please feel free to call 701-628-2951 with any questions.

- **Please answer the health questionnaire on the back side of the form.**

Sincerely,
Becky Fladeland RN
Upper Missouri District Health- Stanley

www.umdhu.org

Flu /COVID Administration Record

Information collected on this form will used to document authorization of receipt of vaccine(s). Information may be shared through the North Dakota Immunization Information system (NDIIS) with other entities in accordance with North Dakota Century Code 23-01-05.3.

PLEASE PRINT ***Answer health questions on the top back of this sheet.***

CLIENT INFORMATION

First Name:	Middle Name:	Last Name:	Date of Birth:	Age:	Gender: *(circle)* Male Female

Mailing Address (Street or Box Number):	Apt Number	Race: *(please check all that apply)*	Birth State or Birth Country:
		☐ White but not Hispanic or Latino ☐ White and Hispanic or Latino ☐ American Indian / Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian / Pacific Islander ☐ Other race ☐ Unknown	
City:			
State: / **Zip Code:**	**County:**		**Occupation:**
Email:			

Home Phone #	Cell Phone#	Work #

ELIGIBILITY

Please check *all* that apply. The information below pertains to the influenza immunization only. There is no cost for the COVID vaccine at this time.

☐ _____ **Medicaid [NUMBER REQUIRED]**
*****DO NOT SEND MONEY. Medicaid will be billed **if** Medicaid number is provided.

☐ **No Insurance (18 and under) ***SEND ***$20.99 FOR FLU VACCINATION*** with this consent form (exact cash or check, payable to UMDHU)

☐ **Self-Pay :** _____

☐ **Insured – Call your insurance company to determine if vaccines are covered when provided by Upper Missouri District Health Unit**. If it is, fill out insurance information. *DO NOT SEND MONEY. You will be billed for any patient responsibility. Call your local UMDHU office for further questions or payment options.

INSURANCE INFORMATION

Primary Insurance or Medicare #	**Policy Holder Name (First MI Last):**	**Policy Holder Relationship to Client:**	**Policy Holder Date of Birth:**
	Insurance Company Name:	**Group #** if applicable**:**	**Policy Holder Gender:** Male Female
	Policy Holder Member ID #:	**Client Member ID #** if different**:**	
Secondary or Supplemental Insurance	**Policy Holder Name (First MI Last):**	**Policy Holder Relationship to Client**	**Policy Holder Date of Birth:**
	Insurance Company Name:	**Group # is applicable:**	**Policy Holder Gender:** Male Female
	Policy Holder Member ID #:	**Client Member ID #** if different**:**	
	Company Pay Name:	**Company Mailing Address:**	

SIGNATURE

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I consent to the administration of the vaccine(s) to be given. A copy of the Vaccine Information Statement has been provided. I have read the information about the vaccine. I had an opportunity to ask questions and believe I understand the benefits and risks of the vaccine.

Information collected on this form will be used to document receipt of vaccine and I consent to the exchange of this information with the ND Immunization Information System.

I agree to pay and am financially responsible for charges not covered by third-party payers. I assign and authorize any third party payer/insurer to make direct payment to Upper Missouri District Health Unit (UMDHU)). I authorize the release of information necessary to process this claim. UMDHU Notice of Privacy Practices is available on request.

Signature: PRINT NAME:	Date:

Select the vaccine(s) you want to be given: **Influenza:** ☐ **High Dose (ages 65+)**
☐ **Influenza (all ages 6months+)**
COVID: ☐ **Pfizer (6 months -17 years old will be given Pfizer only)**
☐ **Moderna** ☐ **Novavax**

Y____N____ Do you feel sick today?
Y____N____ Have you had a serious reaction from a previous vaccination?
Y____N____ Do you have a history of severe allergic reaction (anaphylaxis) to any component of the vaccine including egg protein?
Y____N____ Have you had Guillain-Barré Syndrome, a rare paralyzing illness?
Y____N____ Do you have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome? Do not include high Blood Pressure.
Y____N____ Do you use tobacco?

--------Answer these additional Questions if Receiving COVID vaccine today ----------

Y____N____ Have you received a dose of COVID vaccine? Circle which one: Pfizer Moderna Janssen Novavax
Y____N____ Have you received monoclonal antibodies or convalescent plasma for COVID treatment in past 90 days?
Y____N____ Have you tested positive for COVID in the past 10 days?
Y____N____ Do you have a weakened immune system caused by HIV infection or cancer or do you take immunosuppressive drugs or therapies?
Y____N____ Do you have dermal fillers?
Y____N____ Have you ever had a **severe** allergic reaction (anaphylaxis) to anything? **List:** _____

BELOW IS FOR UMDHU USE ONLY

	Vaccine	CVX	CPT	Route	Lot #	Site
P/VFC	**Fluarix PF (6 mos & up)**	150	90686	IM		LA RA LT RT
P/VFC	**Fluzone PF (6 mos & up)**	150	90686	IM		LA RA LT RT
P/VFC	**Flucelvax (2 yrs & up)**	171	90674	IM		LA RA LT RT
P	**High Dose Fluzone (65 years & up)**	197	90662	IM		LA RA LT RT
P/VFC	Covid Moderna (6mos-11ys) Moderna	311	91322	IM		LA RA LT RT
P /VFC	Covid Moderna (12 yrs & up) Moderna	312	91321	IM		LA RA LT RT
P /VFC	Covid Pfizer(6 mos to 4 yrs) Pfizer	308	91318	IM		LA RA LT RT
P /VFC	Covid Pfizer (5 yrs to 11yrs) Pfizer	310	91319	IM		LA RA LT RT
P /VFC	Covid Pfizer (12 yrs & up) Pfizer	309	91320	IM		LA RA LT RT
P /VFC	Novavax (12 yrs &up) Novavax	313	91304	IM		LA RA LT RT

Vaccine Administrator		**Date Given**	

Revised: 09/23

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Influenza vaccine can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years and older, pregnant people, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections, and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer, or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

In an average year, **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2. Influenza vaccines

CDC recommends everyone 6 months and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against the influenza viruses believed to be likely to cause disease in the upcoming flu season.

Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**
- Has ever had **Guillain-Barré Syndrome** (also called "GBS")

In some cases, your health care provider may decide to postpone influenza vaccination until a future visit.

Influenza vaccine can be administered at any time during pregnancy. People who are or will be pregnant during influenza season should receive inactivated influenza vaccine.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4. Risks of a vaccine reaction

- Soreness, redness, and swelling where the shot is given, fever, muscle aches, and headache can happen after influenza vaccination.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/flu**.