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

LAMOURE COUNTY HEALTH DEPARTMENT INFLUENZA VAR
PO Box 692, Bank North Mall, LaMoure, ND 58458 701.883.5356

PLEASE PRINT INFORMATION ABOUT PERSON TO RECEIVE VACCINE.

Client **Last Name** **First Name** **Middle**		**Date of Birth:**	**Age:**	**Gender:** ☐ **Male** ☐ **Female**	**Birth State**
Address (Street or P.O. Box):	**City:**	**County:**	**State**	**Zip Code:**	
Parent/Guardian Name:	**Home Phone #**	**Cell Phone #**			

Race: ___American Indian or Alaska Native ___Asian ___Black or African American ___Native Hawaiian or other Pacific Islander ___Hispanic/Latino ___Other Race ___Unknown ___White

MOTHER'S Information:
Name: _____
First Middle Last
Mother's Maiden Name: _____

Payment Status (Check all that apply)**:**
Fee can be billed to your INSURANCE or MEDICAID, or paid in cash/check*$50 ADULT or $21 CHILD payable to LCHD.*
☐ Medicaid Eligible - Please write Medicaid #: _____ ☐Primary Insurance ☐ Secondary Insurance
☐ No Insurance ☐ Underinsured (Vaccines not covered by health insurance) ☐Medicare

Name of Primary Insurance Company:_____
Name & Birthdate of Policy Holder:_____
Policy Number: _____ **Group Number if Applicable:** _____
Gender ☐ Male ☐ Female Policy Holder Relationship to Patient: _____
Address of Policy Holder if different than Child: _____
Insurance Company Address: _____
_____
(City) (State) (Zip)

1. **Allergic to Latex? No Yes**
2. **Allergic to Eggs? No Yes**
3. **Allergic to Thimerosol? No Yes**
4. **Had a past history of Guillain-Barre (French Polio)? No Yes**
5. **Previous reaction to a flu shot? No Yes**
6. **Are you pregnant? No Yes N/A**
7. **Live Vaccine in past 30 days? No Yes**
8. **Chronic Disease? No Yes**
9. **Received any blood products or Immune Globulin in the past year? No Yes**
10. **Does the recipient have any problems with his/her immune system (cancer, leukemia, or HIV/AIDS)? No Yes**

IF YOUR CHILD IS UNDER THE AGE OF 9, and has never had two flu shots in a single flu season, your child may need two vaccinations this year to be fully immunized. Please initial in the following box to give permission to LCHD to vaccinate your child with the second influenza vaccine in 4 weeks. Parent/Guardian Initials: _____

NOTE: NASAL MIST IS NOT AVAILABLE THROUGH LCHD THIS YEAR.

ACKNOWLEDGEMENT, AUTHORIZATION AND ASSIGNMENT OF BENEFITS
I have read, or have had explained, the Vaccine Information Statement(s) about the vaccine(s) recommended and the disease(s) for which they provide protection. There was an opportunity to ask questions; all questions were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) discussed and ask that those vaccine(s) be given to me or the person for whom I am authorized to make this request.
If I am the Client, or an individual legally obligated to pay for medical services provided to the Client or a Guarantor of payment, I agree to pay and I am financially responsible for the LaMoure County Health Department's established charges provided to the Client not covered by a third-party payer.
I assign and authorize any third party payer/insurer to make direct payment to the LaMoure County Health Department of all benefits payable for the Client's care (minor not allowed to sign). I authorize the release of any medical or other information necessary to process this claim.

Signature of person to receive vaccine or Legal Guardian:	**Date:**	**School or Business:**
X		

THIS SIDE FOR OFFICE USE ONLY

	Vaccine(s) To Be Given	Route	VIS Date	MFG	Lot Number	U/P	Admin Site	Vaccine Administrator
142	**Fluarix Quad** (6mo-18) **VFC** 90686 *PF* NDC 58160-0885-52	IM	08/15/2019	GSK		U		
155	**Fluzone Quad** (6mo-18) **VFC** 90686 *PF* NDC 49281-0420-50	IM	08/15/2019	GSK		U		
157	**Flulaval Quad** (6mo & ↑) **Private** 90686 *PF* NDC 19515-0816-52	IM	08/15/2019	GSK		P		
144	**Fluarix Quad** (6mo & ↑) **Private** 90686 *PF* NDC 58160-0885-52	IM	08/15/2019	GSK		P		
158	**Fluzone High Dose** (65&↑) **Private** 90662 *PF* NDC 49281-0120-65	IM	08/15/2019	SP		P		
165	**PPSV23** Pneumococcal **Medicare Pays** 90732 Pneumovax 65 yrs & over	IM	10/30/2019	M		P		
166	**PCV13** Pneumococcal **Medicare Pays** 90670 Prevnar 13 65 yrs & over	IM	10/30/2019	PF		P		
112	**Shingrix** (Shingles) 60 yrs & over ***Medicare Does NOT Pay***	IM	10/30/2019	GSK		P		
129	**TDAP** (10 & ↑) ***Medicare Does NOT Pay***	IM	04/01/2020	GSK		P		
128	**TD** (>7) ***Medicare Does NOT Pay***	IM	04/01/2020	SP		P		
Signature and Title of Professionals Administering Vaccine:						**Date Administered:**		

1. **Indicate if state-supplied or privately purchased:** U = Universal, P = Privately purchased
2. **Site Vaccine Given:** LA = Left Arm, RA = Right Arm, LUT = Left Upper Thigh, LLT= Left Lower Thigh, RUT = Right Upper Thigh, RLT= Right Lower Thigh

Tobacco Use (circle those that apply):

Never Current User Former User Second Hand Smoke (Y) (N) Chews Vapes

ND Quits/net Info Given (Y) (N) ND Quits/net Info Denied (Y) (N)