



Public Health

LaMoure County Public Health Department

PLEASE PRINT INFORMATION ABOUT PERSON TO RECEIVE VACCINE.

Client Last Name First Name Middle Date of Birth: Age: Gender: 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 Hispanic/Latino
Asian Other Race
Black or African American Unknown
Native Hawaiian or other Pacific Islander 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 Thimerosal? 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:

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
State Flu 90686 PF	IM	08/06/2021	GSK		U		
Private Flu 90686 PF	IM	08/06/2021	GSK		P		
State Flu Mist 90672 P	IM	08/06/2021	GSK		P		
Private Flu Mist (2-49) 90672 P	Nasal	08/06/2021	MED		P		
High Dose (65&↑) 90662 PF	IM	08/06/2021	SP		P		
PCV20 Pneumonia			PF				
PPSV23 Pneumococcal Medicare Pays 90732 Pneumovax 65 yrs & over	IM	10/30/2019	M		P		
PCV13 Pneumococcal Medicare Pays 90670 Prevnar 13 65 yrs & over	IM	08/06/2021	PF		P		
Shingrix (Shingles) 60 yrs & over Medicare Does NOT Pay	IM	10/30/2019	GSK		P		
TDAP (10 & ↑) Medicare Does NOT Pay	IM	08/06/2021	GSK		P		
TD (>7) Medicare Does NOT Pay	IM	08/06/2021	SP		P		
COVID Moderna (12&↑) 0.50 ml	IM		Moderna				
COVID Moderna Booster 0.25 ml	IM		Moderna				
COVID Moderna (6yr through 11yr) 0.50 ml	IM		Moderna				
COVID Moderna (6mo through 5yr) 0.25 ml	IM		Moderna				
COVID Pfizer Tris (12&↑) 0.30 ml	IM		Pfizer				
COVID Pfizer Booster 0.30 ml	IM		Pfizer				
COVID Pfizer (5yr-11yr) 0.20 ml	IM		Pfizer				
COVID Pfizer (6mo-5yr) 0.20 ml	IM		Pfizer				
COVID Novavax (18&↑) 0.50 ml	IM		Moderna				
Signature and Title of Professionals Administering Vaccine:					Date Administered:		