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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.

☐ _____ **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**
- ☐ **Moderna**

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____ Please list any underlying medical conditions, Please list_____
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(s) To Be Given	CVX	CPT	Route	Lot Number	Admin Site	RX Number
P /State	**Influenza PF (6 mos & up)** Fluarix	140	90656	IM		LA RA LT RT	
P/STATE	**INFLUENZA (6 MOS & UP)** FLUZONE	140	90656	IM		LA RA LT RT	
P / State	**Influenza (6 mos & up)** Flucelvax single dose	153	90661	IM		LA RA LT RT	
PRIVATE	**Influenza- High Dose (65yrs+)** Fluzone	135	90622	IM		LA RA LT RT	
P/State	**Influenza – (9 yrs.+)** Flublok Sanofi	155	90673	IM		LA RA LT RT	
P / State	**Covid Moderna (6mos-11ys)** Moderna	311	91321	IM		LA RA LT RT	
P / State	**Covid Moderna (12 yrs. & up)** Moderna	312	91322	IM		LA RA LT RT	
P / State	**Covid Pfizer (5 yrs. to 11yrs)** Pfizer	310	91319	IM		LA RA LT RT	
P / State	**Covid Pfizer (12 yrs. & up)** Pfizer	309	91320	IM		LA RA LT RT	
P/State	Novavax Novavax	313	91304	IM		LA RA LT RT	
P/State	RSV Adult Arexvy	303	90679	IM		LA RA LT RT	
P/State	RSV Infant Beyfortus	307	90381	IM		LA RA LT RT	
P/State	RSV (Pregnancy 32-36 weeks) (Sept-Jan) Abrysvo	305	90678	IM		LA RA LT RT	

Vaccine Administrator:	Date Given:	
	REVISED 09/2026	