DICKEY COUNTY HEALTH DISTRICT
PO BOX 238
ELLENDALE ND 58436
701-349-4348 FAX: 701-349-3277

Client's Name (Last, First, Middle Initial):	Date of Birth:	Age:	Male	Female

Address (Street or P.O. Box):	City:	State:	Zip Code:	Phone number:

E-mail Address _____

	Please Check Appropriate Box	YES	NO
1.	Have you received a flu vaccination before?		
2.	Have you had a serious reaction to a previous dose of influenza vaccine?		
3.	Have you ever had Guillain-Barre syndrome?		
4.	Are you sick today?		
5.	Do you have health insurance? If yes, please fill in information below.		

Insurance company name: _____ ID number: _____

Name of Policy Holder: _____ Date of Birth: _____

CHILDREN 18 YEARS OF AGE AND YOUNGER:

1.	Is your child enrolled in ND Medicaid? If yes, ID number:			
2.	Is your child Native American or Alaska Native?			

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

A copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Statement(s) has been provided. I have read, or have had explained, the information about the disease(s) and the vaccine(s) listed below. There was an opportunity to ask questions and all questions were answered satisfactorily. I understand the benefits and risks of the vaccine(s) cited, and ask that the vaccine(s) listed below be given to me or to the person named above (for whom I am authorized to make this request).

I authorize the release of any medical or other information necessary to process this claim. 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 Dickey County Health District'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 Dickey County Health District of all benefits payable for the Client's care.

X_____ _____
SIGNATURE DATE

FOR CLINIC USE ONLY **Date of Vaccination: _____**

Vaccine	Route	VIS Date	Mfg. Co.	Lot Number	Dosage	Adm Site	Nurse Signature
Influenza	IM	8/6/2021			0.5 ml	LA RA	