

**DICKEY COUNTY HEALTH DISTRICT
PO BOX 238 ELLENDALE ND 58436
701-349-4348
701-349-3277 fax**

Client's Name (Last, First, Middle Initial):	Date of Birth:	Age:	Male	Female
Address (Street or P.O. Box):	City:	County:	State:	Zip Code:
Home phone number:		Emergency phone number:		

Please check all that apply regarding your child:

- American Indian or Alaskan Native
- Has Medicaid – I.D. number: _____
- Has NO medical insurance or insurance does not cover immunizations.
- Has medical insurance. Insurance company name: _____
- Policy number: _____
- Name of Policy Holder: _____ Date of Birth: _____
- Address (if different than above): _____
- _____

Influenza Screening Questions

	Please Check Appropriate Box	YES	NO
1.	Has your child received a flu vaccination before?		
2.	Has your child had a serious reaction to a previous dose of influenza vaccine?		
3.	Has your child had a serious allergic reaction to eggs or to a component of the influenza vaccine?		
4.	Has your child ever had Guillain-Barre syndrome?		
5.	Does the child to be vaccinated have a long-term problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorders?		
6.	Does the child to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as steroid, or cancer treatment with X-rays or drugs?		
7.	OLDER CHILDREN - Is your child pregnant?		
8.	Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and whom must be in a protective environment (such as in a hospital room with reverse air flow)?		
9.	Has your child received the Chickenpox or Measles, Mumps, Rubella immunizations in the past 30 days?		
10	Is your child receiving aspirin therapy for aspirin-containing therapy?		

Please sign form on back.

Child's Homeroom Teacher _____

Grade _____

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 believe that 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 OF PARENT OR LEGAL GUARDIAN** _____ **DATE**

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

Vaccine(s) to be given	VIS Date	Manufacturer	Lot Number And Exp. date	Dosage	Admin Site	Nurse Signature
Influenza	08/10/10	Sanofi Pasteur		0.5 ml	LA RA	
FluMist	08/10/10	Medimmune		0.1 per nostril	Nasal	