



Student ID #: _____

Do you have the United Health Care Student Insurance Plan? YES NO

Student Influenza Vaccine Consent Form 2020-2021

Fill in all information through the red X. Vaccine Information Statements can be viewed at www.cdc.gov/immunize.

Last Name:		First Name:		Middle Initial:	Age:	Date of Birth:	Gender: (circle) Male Female	
Current Address	Street or PO Box:			Race: (please check <u>all</u> that apply): <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hawaiian Native/Pacific Islander <input type="checkbox"/> White		Born in what state: If not born in US, what country:		
	City:		County:			Ethnicity: <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic		
	State:	Zip Code:			Home or Cell Phone#		Mother's maiden name (if patient is 18 years or younger):	
Health History						Please check ALL that apply: <input type="checkbox"/> I DO NOT have health insurance <input type="checkbox"/> I HAVE Health Insurance. Name of health insurance: _____ <input type="checkbox"/> I HAVE Medicaid insurance		
Please answer all the questions:								✓ Check Yes or No
Feel sick today?								<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any of the following symptoms in the past 14 days: Cough, muscle pain fever (temp > 100.4F), unexpected shortness of breath, chills, or sore throat, loss of taste/odor?								<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been in contact with anyone with confirmed or suspected Coronavirus (COVID-19) infection within the past 14 days?								<input type="checkbox"/> Yes <input type="checkbox"/> No
Ever has a serious reaction after previous vaccines?								<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to medicine, latex or food including eggs or gelatin? Please list: _____								<input type="checkbox"/> Yes <input type="checkbox"/> No
Ever had a seizure; nervous system, muscle or nerve disorder; or Guillian Barre (paralyzing polio)?								<input type="checkbox"/> Yes <input type="checkbox"/> No
Have a weak immune system from HIV, or other diseases?								<input type="checkbox"/> Yes <input type="checkbox"/> No
Received a blood transfusion, blood products or Immune Globulin in the past 12 months?								<input type="checkbox"/> Yes <input type="checkbox"/> No
On medication such as prednisone, cortisone, steroids or medication used to treat cancer or arthritis?								<input type="checkbox"/> Yes <input type="checkbox"/> No
Having x-ray therapy for cancer?								<input type="checkbox"/> Yes <input type="checkbox"/> No
Had MMR vaccine (measles, mumps, and rubella), Chickenpox vaccine or live flu vaccine in last 4 weeks?								<input type="checkbox"/> Yes <input type="checkbox"/> No
Pregnant?								<input type="checkbox"/> Yes <input type="checkbox"/> No
Long term health problem such as heart, lung, asthma, diabetes, kidney or blood disorder?								<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Acknowledgement, Authorization and Assignment of Benefits A</p> <p>copy of the Vaccine Information Statement has been provided, and I have read, or had explained, the information about the disease(s) and the vaccine(s) listed. I had an opportunity to ask questions and believe that I understand the benefits and risks of the vaccine(s). I consent to the administration of the vaccines listed to be given to the person named above, and I am authorized to give this consent. Minot State University Student Health Center (Minot State SHC) Notice of Privacy Practices is available online or by request. I agree to pay, and I am financially responsible for Minot State SHC established charges that are not covered by a third-party payer. The cost of the vaccine is \$25.00 and will be billed to my student account. I assign and authorize any third party payer/insurer to make direct payment to Minot State University Student Health Center. I authorize the release of information necessary to process this claim. Information collected on this form will be used to document receipt of vaccine(s) and may be shared with the ND Immunization Information System and other entities in accordance with ND Century Code 23-01-05.3.</p>								
						DATE: _____		
Signature of client or person authorized to sign on the client's behalf.								
Minot State University Student Health Center OFFICE USE ONLY								
✓	Vaccine(s) to be given	Route*	VIS Date	Manufacturer	Lot #	S/P**	Admin. Site	Person Admin.
	Influenza (private)	IM	8/15/2019	GSK	#N549A Fluarix (GSK) Exp. 6/30/2021	P	RA LA	

Nursing Assessment/Teaching/Vaccine Administration

Date