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

CHILD'S HOMEROOM TEACHER:_____**GRADE:**_____

Parent E-mail Address_____

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

Address (Street or P.O. Box):	**City:**	**State:**	**Zip Code:**	**Emergency phone number:**

	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.	Is your child enrolled in ND Medicaid? If yes, ID number:		
6.	Is your child Native American or Alaska Native?		
7.	Does your child have private health insurance? If yes, please fill in information below.		

Insurance company name:_____ Policy number:_____

Name of Policy Holder:_____Date of Birth:_____

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	**Route**	**VIS Date**	**Mfg. Co.**	**Lot Number**	**Dosage**	**Adm Site**	**Nurse Signature**
Influenza	IM					LA RA	