Minot State Staff and Faculty Flu Vaccine Administration Record 2023-2024

Please complete all boxes and print legibly.

Last name:		First name:		M.I.:
Date of birth:	Age:	Please circle: Male Female	Phone:	
Address:		City:	State:	Zip:

INSURANCE: Flu vaccination CANNOT be given without all insurance information completed.

Sanford Health Insurance ID#	
Policy Holder Name:	Policy Holder Date of Birth:

Please answer all questions:

Do you feel sick today?	Yes	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?	Yes	No
Have you been in contact with anyone with confirmed or suspected Coronavirus (COVID-19) infection within the past 14 days?	Yes	No
Have you had a serious reaction from a previous vaccination?	Yes	No
Do you have any allergies to eggs, latex, food, medicine, or any vaccine? Please list allergies if any: _____	Yes	No
Have you had Guillain-Barre' Syndrome, a temporary severe muscle weakness?	Yes	No
Do you have a chronic health condition? Please list: _____ _____	Yes	No
Have you ever had a pneumonia vaccination?	Yes	No

Authorization and Assignment of Benefits

A copy of the Vaccine Information Statement has been provided, and I have read, or had explained, the information about influenza (8/15/2019) 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. 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.

X _____ **Date:** _____

Signature of client or person authorized to sign on the client's behalf.

MSU STUDENT HEALTH CENTER USE ONLY		
	Influenza Lot # AF749 Exp. 6/30/2024 Fluarix GSK 0.5 cc IM VIS Date 8/6/2021	**Circle Deltoid: Left Right**

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Signature of Vaccine Administrator **Date**

NDIIS	**Submitted to Insurance**	**SHC Reimbursed**	**Developed: 8/28/2015 Updated: 9/12/2023**