ALL YELLOW HIGHLIGHTED AREAS MUST BE COMPLETED LEGIBLY, IN INK.

Child's School:_____

Grade:_____ Teacher:_____

WelCore Health LLC
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Print Child's Name (Last, First and Middle, required):	**Date of Birth:** **Age:**	**Gender:** Male Female	**Native American / Alaska Native?** (circle) Yes No

Mailing Address:	**City:**	**:State:** **Zip Code:**	**Home or Cell Phone #:** **Work #:** **Can we text or e-mail you with questions?** Yes No **Write E-mail or Phone Number (include area code):**

TO DETERMINE PAYMENT: *Please check appropriate box below.*

- ❑ **Medicaid Number**_____
  **Do not send money. Medicaid will be billed.*
- ❑ **No Insurance.** ****We request a $20.99 donation to cover vaccine administration.***
  (cash or check, payable to WelCore Health).
  **No child will be turned away regardless of the ability to pay for vaccine administration.*
- ❑ **My insurance doesn't pay for flu vaccine.** ****We request a $20.99 donation to cover vaccine administration.***
  (call # on back of insurance card to determine). (cash or check, payable to WelCore Health).
  **No child will be turned away regardless of the ability to pay for vaccine administration.*
- ❑ **Insured – my insurance pays for flu vaccine.**
  If your insurance company is listed *in the box on the right,* ***do not send money. We will bill insurance.***

POLICY HOLDER INFORMATION:

Policy Holder Name (Last, First, MI):_____ **Date of Birth:**_____
Gender: Male Female Policy Holder Relationship to Child:_____
Insurance Company Name:_____
Policy Number:_____ **or Medica 9 digit ID Number:**_____

We accept insurance from:

Aetna

Blue Cross Blue Shield (any state)
Blue Plus
Caring for Children
Federal Employee Program
ND Public Employee Retirement System (NDPERS)
Preferred Blue
SelectChoice
Employer Provider Network (EPNI)

Humana
Choice Care Network

Medica

Medicaid

Medicare

Medicare Advantage

Railroad Medicare

Sanford Health

United Health Group

Vaccines for Children (VFC)
We provide free vaccine and low cost vaccine administration for eligible children including uninsured, underinsured, Native American and Alaska Native.

Please circle a response.

Yes	No	Has your child had a serious reaction to flu vaccine in the past? Describe Symptoms:
Yes	No	Is your child allergic to **eggs,** gentamicin, arginine or gelatin?
Yes	No	Is your child on medication? If yes list meds:
Yes	No	Has your child received Measles, Mumps, and Rubella, Chicken Pox or FluMist in the past four weeks? Vaccine received: Date:
Yes	No	**Children 6 mo. – 8 years: Did the child receive a total of at least 2 total doses of flu vaccine since 2010?** *If no or unknown give 2 doses four weeks apart. If yes, give 1 dose.*

Does your child have any of the following? *Check* ***all*** *that apply.* ❑ NONE apply

❑ asthma	❑ heart disease	❑ neurological disease	❑ Guillain-Barre Syndrome
❑ wheezing (2-4 yrs old)	❑ kidney disease	❑ neuromuscular disease	❑ weakened immune system
❑ blood disorder	❑ liver disease	❑ lung disease	❑ anemia ❑ diabetes

Yes	No	Is your child in close contact with a person who is in a protected environment in a hospital?
Yes	No	Is your child on long term aspirin therapy?
Yes	No	Is your child pregnant?

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS: A copy of the **Vaccine Information Statement has been provided**. I have read the information about influenza and flu vaccine. I had an opportunity to ask questions and believe I understand the benefits and risks of the vaccine. **I consent to the administration of the vaccine to be given to the person named above and I am authorized to give this consent.** Information collected on this form will be used to document authorization of receipt of vaccine and I consent to the exchange of this information with the ND Immunization Information System and with other entities in accordance with ND Century Code 23-01-05.3. As an individual I am legally obligated to pay for medical services provided to the client or a guarantor of payment, **I agree to pay and am financially responsible** for the established charges provided to the client not covered by third-party payers. I assign and **authorize any third party payer/insurer** to make direct payment to WelCore Health. I authorize the release of any medical or other information necessary to process this claim. I acknowledge that I have been provided with WelCore's Notice of Privacy Practices. It is available on line at www.welcorehealth.com.

SIGNATURE OF PARENT OR LEGAL GUARDIAN_____DATE_____

I prefer my child receive: *(circle)* **FluMist (nasal mist) Flu shot I have no preference** (*FluMist is more effective in young children.)*
If FluMist is not recommended, your child will receive a flu shot. Sick or uncooperative children will not be vaccinated.

OFFICE USE ONLY:

Vaccine	Route	Vis Date	Mfg.	Lot Number	State or Private	Admin. Site	Nurse's Initials
LAIV FluMist 2-49 yrs	IN	7/26/13	Medimmune			IN	
IIV3 IIV4	IM	7/26/13	SP MER			RD LD RT LT	

Assessment/ Teaching Nurse: Does the Child Feel ill today? Yes No

Comments: