Site_____ **Teacher**_____ **Grade**_____

WelCore Health, LLC. 718 Oak Street, Grand Forks, ND 58201-4460, EIN: 27-5414185, NPI: 1760780126,
Office: 701-330-4216, Fax 1-800-958-7702 maggiesoeby@gmail.com, www.welcorehealth.com (August 2021)

Print: Last Name, First Name, Middle Initial:	**Date of Birth:**	**Age:**	**Circle one:** Male Female	**Circle one or more:** Native American/ Alaska Native, Black, Asian, White; Hispanic, Not Hispanic	**Can we text or e-mail you with questions? (circle)** Yes No
Mailing Address:	**City, State, 9 Digit Zip Code:**	**MANDATORY: Phone Number (include area code), Email (optional)**			

We accept the listed insurances. Circle your insurance.	Health Cost Solution	Medica *	Preferred One	Tricare 4 Life
Aetna	Health EZ	Medicaid	Railroad Medicare	United HealthCare
Blue Cross Blue Shield	Health Partners	Medicare Part B	Sanford Health *	UCare/MHCP
Cigna	Humana	Medicare Advantage Plans	Tricare West	Uninsured

***Not all insurance plans cover vaccines by WelCore Health. You are responsible for the cost of the vaccine/vaccine administration if your insurance does not pay. Call the number on the back of your insurance card to check for coverage.**

Insurance Policy holder: How are you related to person being vaccinated? Self_____ Parent/Guardian_____ Spouse_____

Last Name _____ **First Name** _____ **MI**_____ Date of Birth_____ Male/Female_____

Policy/Member ID Number_____ **Group Number**_____

Medicaid/Medicare #:

If you want your child to receive the flu or COVID vaccine complete, sign, and return this form to school as soon as possible. Check the school website for dates and times.

*For uninsured **children** we request a $20.99 donation to cover vaccine administration. *No child will be turned away regardless of the ability to pay for vaccine administration. (cash/ check, payable to **WelCore Health**).*

Vaccine is free for those 18 years and younger who are American Indian, Alaska Native, on Medicaid, are Uninsured or Underinsured (insurance doesn't cover vaccines).

Please indicate which vaccine you want your child to receive:

Pfizer COVID-19_____ Injection_____ Flumist_____ No Preference_____

Yes	No	Has the person to be vaccinated experience a severe allergic reaction (e.g. anaphylaxis) to food, medicine, vaccine, or any other injectable therapy? If yes, please specify:
Yes	No	Has the person to be vaccinated had Guillain-Barre Syndrome after a vaccine?
Yes	No	**Flu vaccine for children 6 months – 8 years: Has your child received a total of at least 2 doses of flu vaccine in the past?** *If no or unknown give 2 doses four weeks apart. If yes, give 1 dose.*
Yes	No	Do any of the conditions below apply to you? **If yes, do not get FluMist**

- Pregnant or breastfeeding
- Immunocompromised or caring for someone who is immunocompromised
- Have a history of asthma or wheezing
- Cochlear implant or other immune system problems
- 2-17 years old on aspirin therapy
- Have taken influenza antiviral medication in the past 48 hours,
- Have diabetes or other chronic diseases

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS: A copy of the **Vaccine Information Statement has been provided**. I have read the information. 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 online at www.welcorehealth.com.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **Date**

OFFICE USE ONLY:

Vaccine	Route	Vis Date	Mfg.	Lot Number	State or Private	Admin. Site	Nurse's Initials & Date
Influenza Inactive	IM	08/06/2021	Seq SP GSK		S P	RD LD RT LT	
Flumist	Nasal	08/06/2021	AZ		S P	Nose	
COVID-19	IM				S	RD LD RT LT	

Does the person to be vaccinated feel ill today? Yes/No Comments: