**City-County Health District (3) Vaccine Administration Record**

**415 2nd Ave NE, Ste. 101, Valley City, ND 58072-3060 Phone: 701-845-8518**

Information collected on this form will be used to document authorization of receipt of vaccine(s). Information may be shared through the North Dakota Immunization Information System (NDIIS) with other entities in accordance with North Dakota Century Code 23-01-05.3.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Print Patient’s Name** (Full Last, First, Middle Name): | | | Maiden Name | | Date of Birth: | Age: | Gender:  □ Male □ Female | |
| Address (Street or PO Box): | | City: | | | County: | State: | | Zip Code: |
| Primary Phone # | | Work Phone# | | | Birth State (or country if not US) | | | |
| Race: (check all that apply)  \_\_ White \_\_ American Indian or Native Alaskan \_\_ Asian \_\_ Native Hawaiian or other Pacific Islander  \_\_ Black or African American | | | | Mother’s Information **(if client is age 18 or younger)**  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last First Middle  Mother’s Maiden Name **(required for children for ND immunization registry) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| Hispanic or Latino Yes No | | | |
| Name of Responsible Financial Party : | Address if different from patient’s address: | | | | | Previous COUNTY of Residence | | |
| INSURANCE INFORMATION \_\_\_\_**No Insurance**  **Medicare Part B #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Medicaid #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Other Insurance:** Primary Insurance Name and Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ph #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number (if applicable):\_\_\_\_\_\_\_\_\_\_ Payer ID(if applicable):\_\_ \_\_ \_\_ \_\_ \_\_  **Policy Holder’s** Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial\_\_\_\_\_  Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender □ Male □ Female Policy Holder Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Secondary Insurance (if applicable): Additional space on back. | | | | | | | | |

For School Clinics School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_ Teacher:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The following questions refer to the person receiving the vaccination today:**

**Complete questions 1-6 for flu shot and 1-12 for all other vaccines.**

1. Y N Are you ill today?

2. Y N Have you ever had a serious reaction after receiving any vaccine?

3. Y N Are you allergic to any foods, medications, vaccine component or latex? Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Y N Do you have a history of Guillian Barre (French Polio)?

5. Y N Do you have a weakened immune system due to disease, medication, or cancer treatment?

6. Y N Are you pregnant or planning on becoming pregnant during the next month?

7. Y N In the past 4 weeks, have you received any live vaccines (FluMist, MMR, Chickenpox, Shingles)?

8. Y N Do you have a chronic disease such as asthma, diabetes, heart condition, HIV, etc.?

9. Y N Have you received a blood transfusion/product, gamma globulin or antiviral drug in past year?

10. Y N (Only for children) Are they on long term aspirin therapy, have asthma, or had wheezing during the last year?

11. Y N Have you, a sibling or parent ever had a seizure, brain, or nervous system disorder?

12. Y N If your child is a baby, have you ever been told he/she has had intussusception (bowel disorder)?

## ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I hereby authorize City-County Health District to release any information concerning my visit here to process any third party claim. I assign and authorize any third party payer/insurer to make direct payment to the Local Public Health Unit of all benefits payable for the Client’s care. I give my permission for CCHD to administer the vaccines noted on the back of this consent form. I acknowledge receipt of CCHD’s “Notice of Privacy Practices.”

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. 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 be given to me or to the person named above (for whom I am authorized to make this request)

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE OF PATIENT OR RESPONSIBLE PERSON (must be 18 or older) DATE**

**FOR OFFICE USE ONLY:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| VFC Eligiblity:  **□** Medicaid Eligible □ Other State Eligible  □ American Indian or Native Alaskan □ No Insurance  □ Underinsured (Vaccines not covered by health insurance)  □ Insured (Vaccines covered by health insurance – Not VFC eligible) | | | | | **“A-A-R” – Tobacco Use & Exposure:**  **A)-**Do you currently use tobacco? 🞏 Yes 🞏 No **A)-**If YES, Advised to quit? 🞏 Yes 🞏 No  Are you exposed to SHS? 🞏 Yes 🞏 No  **R)**-Referred to Quitline/Local Pgm? 🞏 Yes 🞏 No | | | |
|  | | | | | | | | |
| **S/P1** | **Vaccine(s) To Be Given** | **VIS Date** | **Mfr.**  **(circle)** | **Lot Number** | | **Route** | **Admin. Site**  **(circle)** | **Nurse**  **Initial** |
|  | DTaP (diphtheria-tetanus-pertussis) | 5/17/07 | SP GSK |  | | IM | LA RA LT RT |  |
|  | DTaP/IPV (Kinrix) | 5/17/07 7/20/16 | GSK |  | | IM | LA RA LT RT |  |
|  | DTaP/IPV/Hib (Pentacel) | 5/17/07 7/20/16  4/2/15 | SP |  | | IM | LA RA LT RT |  |
|  | Hep A (HepatitisA) Ped \_\_\_\_ Adult\_\_\_\_ | 7/20/16 | M GSK |  | | IM | LA RA LT RT |  |
|  | Hep B (Hepatitis B) Ped \_\_\_\_ Adult\_\_\_\_ | 7/20/16 | M GSK |  | | IM | LA RA LT RT |  |
|  | Hib (Haemophilus influenzae B) | 4/2/15 | SP M |  | | IM | LA RA LT RT |  |
|  | HPV-9 (Human Papillomavirus) | 3/31/16 | M |  | | IM | LA RA LT RT |  |
|  | IPV (inactivated polio vaccine) | 7/20/16 | SP |  | | IM/SQ | LA RA LT RT |  |
|  | MMR (Measles-Mumps-Rubella) | 4/20/12 | M |  | | SQ | LA RA LT RT |  |
|  | MMR/Varicella (ProQuad) | 5/21/10 | M |  | | SQ | LA RA LT RT |  |
|  | MCV-4 (Meningococcal Conj.) Menactra | 3/31/16 | SP |  | | IM | LA RA LT RT |  |
|  | Men B (Bexsero) | 8/9/16 | GSK |  | | IM | LA RA LT RT |  |
|  | PCV-13 (Pneumococcal Conjugate) | 11/5/15 | W |  | | IM | LA RA LT RT |  |
|  | PPV23 (Pneumococcal Polysaccharide) | 4/24/15 | M |  | | IM/SQ | LA RA LT RT |  |
|  | Rotavirus | 4/15/15 | M GSK |  | | PO |  |  |
|  | Td (tetanus-diphtheria) | 2/24/15 | SP MBL |  | | IM | LA RA LT RT |  |
|  | Tdap (tetanus-diphtheria-pertussis) | 2/24/15 | SP GSK |  | | IM | LA RA LT RT |  |
|  | Varicella (chickenpox) | 3/13/08 | M |  | | SQ | LA RA LT RT |  |
|  | Zostavax (Shingles) | 10/06/09 | M |  | | SQ | LA RA LT RT |  |
|  | Fluzone Quad 0.25 ml – PF (6-35 mos.) | 8/7/15 | SP |  | | IM | LA RA LT RT |  |
|  | Fluarix Quad 0.5 ml - PF | 8/7/15 | GSK |  | | IM | LA RA LT RT |  |
|  | Fluzone Quad 0.5 ml - PF | 8/7/15 | SP |  | | IM | LA RA LT RT |  |
|  | Flucelvax Quad 0.5ml PF State -4 y and older | 8/7/15 | Seqirus |  | | IM | LA RA LT RT |  |
|  | FluLaval 0.5 ml (multi-dose vial) - Quad | 8/7/15 | GSK |  | | IM | LA RA LT RT |  |
|  | Fluzone HD 0.5 ml – age 65 & up - Tri | 8/7/15 | SP |  | | IM | LA RA LT RT |  |
| **1 S = State / P = Private** | | | | | | | | |

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| **Date Vaccine Administered:** | **Signature of Administrator** | **Next appointment** |

#### SECONDARY INSURANCE INFORMATION (if needed)

Secondary Insurance Name and Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number(if applicable):\_\_\_\_\_\_\_\_\_\_\_\_ Payer ID(if applicable):\_\_ \_\_ \_\_ \_\_ \_\_

Policy Holder’sLast Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender □ Male □ Female Policy Holder Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Rev. 9-16)