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

**415 2nd Ave NE, Ste. 101, Valley City, ND 58072-3011 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.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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. | | | | | | | | |

**Check vaccines requested:** (Tdap and meningitis vaccines are required for 7th grade entry; HPV series is a recommended series)

□ Tdap (tetanus, diphtheria and pertussis)

□ Meningitis (Menactra)

□ HPV series (Gardasil) - Checking this box gives permission to give the 3-dose series. See letter for more information.

**School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Screening Questions**

1. Y N Is the child sick today? If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Y N Does he/she have allergies to medicines, foods, a vaccine component, or latex?

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Y N Is he/she on any medications? If yes, list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Y N Has he/she had a serious reaction to a vaccine in the past? If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Y N Has he/she had a seizure or other nervous system problem? If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Y N Does he/she have a chronic health condition? If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Y N Is she pregnant or is there a chance of becoming pregnant in the next month?

## 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 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 on back 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 Qualified □** Yes If yes, check one: **□** Medicaid **□** Native American **□** No insurance  **□** No **□** Has health insurance that does not pay for vaccines **□** Other state eligible | | | | | |
| Signature of Vaccine Administrator | | | Title of Vaccine Administrator | | Date Vaccine |
| **S/P** | **Vaccine(s) To Be Given** | **VIS Date** | **Mfr.1** | **Vaccine Lot Number** | **Injection Site2/**  **IM** |
|  | HPV-9 | 3/31/16 | MSD |  |  |
|  | Tdap | 2/24/15 | GSK |  |  |
|  | MCV4 (Menactra) | 3/31/16 | SP |  |  |
|  |  |  |  |  |  |
| **VFC Qualified □** Yes If yes, check one: **□** Medicaid **□** Native American **□** No insurance  **□** No **□** Has health insurance that does not pay for vaccines **□** Other state eligible | | | | | |
| Signature of Vaccine Administrator | | | Title of Vaccine Administrator | | Date Vaccine |
| **S/P** | **Vaccine(s) To Be Given** | **VIS Date** | **Mfr.1** | **Vaccine Lot Number** | **Injection Site2/**  **IM** |
|  | HPV-9 | 3/31/16 | MSD |  |  |
|  |  |  |  |  |  |
| **VFC Qualified □** Yes If yes, check one: **□** Medicaid **□** Native American **□** No insurance  **□** No **□** Has health insurance that does not pay for vaccines **□** Other state eligible | | | | | |
| Signature of Vaccine Administrator | | | Title of Vaccine Administrator | | Date Vaccine |
| **S/P** | **Vaccine(s) To Be Given** | **VIS Date** | **Mfr.1** | **Vaccine Lot Number** | **Injection Site2/**  **IM** |
|  | HPV-9 | 3/31/16 | MSD |  |  |
|  |  |  |  |  |  |

**1** Manufacturer **2 Site Vaccine Given**

**“A-A-R”- Tobacco Use & Exposure: J F M A M J J A S O N D**

**A)-**Do you currently use tobacco? **Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N**

Are you exposed to SHS? **Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N**

**A)-If YES,** Advised to QUIT? **Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N**

**R)-**Referred to **Quitline**/Local Pgm? **Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N**

Do you exercise regularly? Y **N Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N**

Do you eat 7 fruits/veggies daily? **Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N**

MSD = Merck & Co., Inc. RA = Right Arm

GSK = GlaxoSmithKline LA = Left Arm

SP = Sanofi Pasteur

(Rev. 3-16)