



Public Health

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.

Print Patient's Legal Name (Full Last, First, Middle Name): Maiden Name Date of Birth: Age: Gender:
Address (Street or PO Box): City: County: State: Zip Code:
Primary Phone # Work Phone# Birth State (or list country if not US)
Race: (check all that apply) 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 (check if applies)
\*\*Name as it appears on insurance card:
PLEASE NOTE: CCHD cannot Accept United Healthcare Insurance for immunizations.
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 Policy Holder Relationship to Client:
Secondary Insurance (if applicable):

For School Clinics School: Grade: Teacher:

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

- 1. Y N Is the person to be vaccinated sick today?
2. Y N Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?
3. Y N Does the person to be vaccinated have an allergy to eggs, meds, vaccine or latex? Describe
4. Y N Has the person to be vaccinated ever had Guillain Barre syndrome (French Polio)?
5. Y N Is the person to be vaccinated pregnant?

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 bottom 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:

(Form rev. 9-18)

VFC Eligibility (18 and under - Check all that apply): Insured (Vaccines covered by health insurance)
Medicaid Eligible No Insurance
American Indian or Native Alaskan
Underinsured (Vaccines not covered by health insurance)
Tobacco Use: Y/N Advised to Quit: Y/N
Referred: Y/N Secondhand Smoke Exposure: Y/N
S/P Fluorix Quad 0.5 ml - PFS (6 mo. and up) 8/7/15 GSK IM LA RA LT RT
S/P Fluzone Quad 0.25 ml - PFS (6-35 mos.) 8/7/15 SP IM LA RA LT RT
S/P Fluzone Quad 0.5 ml - PFS/SDV (3y & up) 8/7/15 SP IM LA RA LT RT
S/P Fluzone HD Tri 0.5 ml - (65 & up) 8/7/15 SP IM LA RA LT RT
S = State / P = Private (circle) Vaccine VIS Mfr Lot Circle route Site Nurse signature Date given

NDIIS Patagonia Registered Nurse Documentation Scanned