VACCINE ADMINISTRATION RECORD

BIRTH TO 18 YEARS **Emmons County Public Health** **Clinic Identification Number: 49**

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.
(Revised 06/18/20)

First Name:	Middle Name:	Last Name:	Date of Birth:

Street Address:	PO Box:	City:	State:	Zip Code:

County: □ Emmons □ If Other, please list: _____	Mother's Maiden Name:	Cell Phone:	Home Phone:

Race: Please check all that apply:	□ White □ Black or African American □ American Indian □ Filipino □ Asian □Asian Indian □ Hispanic □ If Other, please list:

Gender: □ Male □ Female	**State child was born in:** □ ND	□ If Other, please list:

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS
(Please read and initial each)

_____ (initial) I acknowledge that I have been provided with Emmons County Public Health's Notice of Privacy Practices. I understand I may request an additional copy of the Notice at future contacts with Emmons County Public Health (ECPH).

_____ (initial) I authorize the release of any medical or other information necessary to process this claim.

_____ (initial) I authorize the release of immunization records to the child's daycare or school.

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

_____ (initial) If I am the Client, or an individual legally obligated to pay for medical services provided to the Client or a Guarantor of payment, I agree to pay and I am financially responsible for ECPH's established charges provided to the Client not covered by a third-party payer. I assign and authorize any third-party payer/insurer to make direct payment to ECPH of all benefits payable for the Client's care.

THESE QUESTIONS ARE TO BE ANSWERED BY THE PERSON RECEIVING THE VACCINE OR PARENT/GUARDIAN MAKING THE REQUEST.
Questions 1-6 are used to determine if children 18 years of age or younger qualifies for the federally funded immunization program titled Vaccine for Children (VFC).

Is your child enrolled in Medicaid?	□ Yes □ No □ Unknown
If "yes", is Medicaid □ Primary Insurance □ Secondary Insurance Medicaid #: _____	
Does your child have private health insurance?	□ Yes □ No □ Unknown
Does your child's private health insurance cover vaccinations?	□ Yes □ No □ Unknown
Is your child Native American or Alaskan Native?	□ Yes □ No □ Unknown
HAS OR DOES THE PERSON RECEIVING THE VACCINE:	
Had any problems after receiving previous vaccines?	□ Yes □ No □ Unknown
Have any allergies to food, medicine, or any vaccine?	□ Yes □ No □ Unknown
Have a brain problem or ever had a seizure?	□ Yes □ No □ Unknown
Have any problems with his/her immune system, such as cancer, leukemia, or HIV/AIDS?	□ Yes □ No □ Unknown
Taken cortisone, prednisone, other steroids, or anti-cancer drugs, or x-ray treatments in the past 3 months?	□ Yes □ No □ Unknown
Received any blood products or Immune Globulin in the past year?	□ Yes □ No □ Unknown
Had chickenpox? If yes, date of disease:	□ Yes □ No □ Unknown
Received any vaccines in the past four weeks?	□ Yes □ No □ Unknown
Is the person receiving the vaccine pregnant?	□ Yes □ No □ Unknown
Is the person receiving the vaccine sick today?	□ Yes □ No □ Unknown
Have you read the important Information Statement about the vaccine you or your child will be receiving?	□ Yes □ No
_____ (initial) ***I have received HPV Vaccine Information but am refusing vaccination at this time***	

To be completed by ECPH Employee:	
Tobacco Use: □ Current □ Former □ Never	□ Fax Referred to Quitline □ Quitline/Quitnet information given
Second Hand Smoke Exposure: □ Home □ Work □ None	□ SHS information given □ No action taken

X	Date:
Signature of Client or Parent/Guardian	

				AM / PM
Patient	**Date of Birth**	**Date Injection Given**	**Time Injection Given**	

Primary Insurance: □ BCBS □ Sanford Health Plan □ Medicaid □ Private Pay	Policy Holder:	Policy Holder's Date of Birth:
□ Copy of Insurance Card Enclosed in Chart	Policy Number:	Group Number:

	Vaccine(s) to be given	VIS Date	Lot Number	Admin Site		Private State		Nurse Signature
	DTaP (diphtheria-tetanus-pertussis)	08/24/18		LA LT	RA RT	P	S	
	DTaP/Hib/IPV (Pentacel)	08/24/18 04/02/18 10/30/19		LA LT	RA RT	P	S	
	DTaP/IPV (Kinrix)	08/24/18 10/30/19		LA LT	RA RT	P	S	
	Hib – Haemophilus Influenzae B (Pedvax Hib) PRP-OMP	04/02/15 3 doses		LA LT	RA RT	P	S	
	Hep A (Hepatitis A) 12 mo. Thru 19 year's old	07/20/16		LA LT	RA RT	P	S	
	Hep B (Hepatitis B) Birth thru 19 year's old	10/12/18		LA LT	RA RT	P	S	
	HPV-9 (Human Papillomavirus)	12/02/16		LA LT	RA RT	P	S	
	MMR	02/12/18		LA LT	RA RT	P	S	
	MMRV	02/12/18		LA LT	RA RT	P	S	
	MCV-4 (Meningococcal Conjugate)	08/24/18		LA LT	RA RT	P	S	
	PCV-13 (Pneumococcal Conjugate)	11/05/15		LA LT	RA RT	P	S	
	ROTAVIRUS (3 DOSE)	10/30/19		PO		P	S	
	Td (tetanus-diphtheria)	04/11/17		LA LT	RA RT	P	S	
	Tdap (tetanus-diphtheria-pertussis)	02/24/15		LA LT	RA RT	P	S	
	VARICELLA (Chickenpox)	02/12/18		LA LT	RA RT	P	S	
	DTaP/HepB/IPV (Pediarix)	08/24/18 10/12/18 10/30/19		LA LT	RA RT	P	S	
	IPV	10/30/19		LA LT	RA RT	P	S	
	MEN B – BEXSERO	08/09/16		LA LT	RA RT	P	S	
	INFLUENZA (Split Dose) Age 6 mo thru 2 years of age	08/07/15		LA LT	RA RT	P	S	
	INFLUENZA Age 3 thru Adult	08/07/15		LA LT	RA RT	P	S	
				LA LT	RA RT	P	S	
				LA LT	RA RT	P	S	