City-County Health District – 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.

PATIENT INFO: Name (Full Last, First, Middle):	Maiden Name	Date of Birth:	Age:	Gender: ☐ Male ☐ Female
Address (Street or PO Box):	City:	County/School:	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

Hispanic or Latino? Yes No

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)** ______________________________

Name of Responsible Financial Party:	Address <u>if different</u> from patient's address:	Previous COUNTY of Residence

INSURANCE INFORMATION: ***PLEASE NOTE: CCHD <u>cannot accept UnitedHealthcare</u> insurance for immunizations!***

NO INSURANCE (check if applies) _______

Medicaid # ________________________________

Other Insurance: Primary Insurance Name: ____

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: ______________________

Check vaccine requested:

Required – 6th grade

____ Meningitis (Menactra/Meningococcal ACWY)
____ Tdap (tetanus/pertussis/diphtheria)

Recommended – 6th grade

____HPV (Gardasil)
____COVID-19

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

<u>Complete screening questions</u>

1. Y N Are you ill today? If yes, explain__________________________
2. Y N Have you ever had a serious reaction after receiving any vaccine? If yes, explain_________________________
3. Y N Are you allergic to any foods, medications, vaccine component or latex? If yes, explain____________________
4. Y N Are you pregnant or planning on becoming pregnant during the next month?
5. Y N Do you have a chronic disease such as asthma, diabetes, heart condition, HIV, etc.? If yes, explain__________
6. Y N Have you, a sibling or parent ever had a seizure, brain, or nervous system disorder? If yes, explain__________

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 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 Eligibility:	"A-A-R" – TOBACCO USE & EXPOSURE:
☐ 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**)-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/P[1]	Vaccine(s) To Be Given	VIS Date	Mfr. (circle)	Lot Number	Route	Admin. Site (circle)	Nurse Initial
	DTaP (diphtheria-tetanus-pertussis)	8/6/21	SP GSK		IM	LA RA LT RT	
	DTaP/IPV (Kinrix)	8/6/21	GSK		IM	LA RA LT RT	
	DTaP/IPV/Hib (Pentacel)	8/6/21	SP		IM	LA RA LT RT	
	Hep A (HepatitisA) Ped ____ Adult____	10/15/21	M GSK		IM	LA RA LT RT	
	Hep B (Hepatitis B) Ped ____ Adult____	8/15/21	M GSK		IM	LA RA LT RT	
	Hib (Haemophilus influenzae B)	8/6/21	SP M		IM	LA RA LT RT	
	HPV-9 (Human Papillomavirus)	8/6/21	M		IM	LA RA LT RT	
	IPV (inactivated polio vaccine)	8/6/21	SP		IM/SQ	LA RA LT RT	
	MMR (Measles-Mumps-Rubella)	8/6/21	M		SQ	LA RA LT RT	
	MMR/Varicella (ProQuad)	8/6/21	M		SQ	LA RA LT RT	
	MCV-4 (Meningococcal Conj.) Menactra	8/6/21	SP		IM	LA RA LT RT	
	Men B (Bexsero)	8/6/21	GSK		IM	LA RA LT RT	
	PCV-13 (Pneumococcal Conjugate)	2/4/22	W		IM	LA RA LT RT	
	PPV23 (Pneumococcal Polysaccharide)	10/30/19	M		IM/SQ	LA RA LT RT	
	Rotavirus	10/15/21	M GSK		PO		
	PCV20 (Pneumococcal Conjugate)	2/4/22	Pfizer		IM	LA RA LT RT	
	Tdap (tetanus-diphtheria-pertussis)	8/6/21	SP GSK		IM	LA RA LT RT	
	Varicella (chickenpox)	8/6/21	M		SQ	LA RA LT RT	
	Shingrix (Shingles)	2/4/22	GSK		IM	LA RA LT RT	
	Fluarix Quad 0.5 ml – PFS 6 mos. +	8/6/21	GSK		IM	LA RA LT RT	
	Fluzone Quad 0.5 ml – PFS 6 mos. +	8/6/21	SP		IM	LA RA LT RT	
	Flucelvax Quad 0.5ml PFS State 19+	8/6/21	Seqirus		IM	LA RA LT RT	
	Fluzone HD 0.5 ml – age 65 & up - Tri	8/6/21	SP		IM	LA RA LT RT	
	Pfizer 12 & up		Pfizer		IM	LA RA LT RT	

[1] S = State / P = Private

Date Vaccine Administered:	Signature of Administrator	Next appointment

(Rev. 3/2022)