VACCINE ADMINISTRATION RECORD

Foster County Public Health
881 Main Street, Carrington, ND 58421
(701)652-3087

Clinic ID Number 46

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 (Last, First, Middle Initial):		Date of Birth:	Age:	Gender: ☐ Male ☐ Female
Address (Street or PO Box):	City:	County:	State:	Zip Code:
Home Phone #	Cell #	Work #		
Name of Responsible Financial Party :	Address if different from Patient's address:			

☐ **Native American** ☐ **Alaskan Native** ☐ **No Insurance** ☐ **Underinsured (Vaccines not covered by health insurance)**
☐ **Insured (Vaccines covered by health insurance – Not VFC eligible)** ☐ **Medicaid– Enter Number**_____

POLICY HOLDER INFORMATION FOR INSURANCE

Name Of Insurance Company _____ State of Insurance_____

*Last Name:_____ First Name_____ Middle Initial_____

Date of Birth:_____ Policy Holder Relationship to Client: _____

*Policy Number:_____ Group Number if Applicable:_____

Screening Questions for person getting vaccinated

1. **Are you sick today?----------Yes☐ No☐ Don't Know☐**
2. **Do you have allergies to any medications, food, latex, or vaccine?----------Yes☐ No☐ Don't Know☐**
3. **Have you had a serious reaction to any vaccine in the past?----------Yes☐ No☐ Don't Know☐**
4. **Do you have a health problem with asthma, lung disease, heart disease, kidney disease, Metabolic disease (e.g., diabetes), or a blood disorder?---------- Yes☐ No☐ Don't Know☐**
5. **Have you had a seizure, brain, or any other nervous system problem?--------Yes☐ No☐ Don't Know☐**
6. **Do you have cancer, leukemia, AIDS, or another immune system problem?--Yes☐ No☐ Don't Know☐**
7. **Do you take cortisone, prednisone, other steroids or anticancer drugs, or had radiation treatments?----------Yes☐ No☐ Don't Know☐**
8. **Have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year?----------Yes☐ No☐ Don't Know☐**
9. **For Women: Are you pregnant or is there a chance you could become pregnant in the next month?----------Yes☐ No☐ Don't Know☐**
10. **Have you received any vaccinations in the past 4 weeks?----------Yes☐ No☐ Don't Know☐**
11. **Have you ever had Guillain-Barre Syndrome?----------Yes☐ No☐ Don't Know☐**
12. **Do you currently ☐smoke, ☐chew, ☐have exposure to secondhand smoke No☐**
13. **Are you a prior ☐smoker, ☐chewer, ☐electronic nicotine user? No☐**

Quit date:_____ Quitline Referral Accepted Yes☐ N/A☐ Referral Refused☐

(Please initial) **ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS**

_____ I authorize the release of any medical or other information necessary to process this claim. I consent to data entry into the ND state registry.

_____ 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)

_____ 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 the Local Public Health Unit'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 the Local Public Health Unit of all benefits payable for the Client's care. (minor not allowed to sign)

X_____ _____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PERSON RELATIONSHIP TO PATIENT DATE

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Date Vaccine Administered:

✓	Vaccine(s) To Be Given	VIS Date	Mfr. (circle)	Lot Number	Route	Admin. Site (circle)	Nurse Signature
	DTaP (diphtheria-tetanus-pertussis)	11/5/15	GSK		IM	R Upper Arm L Lower Thigh	
	DTaP/IPV (Kinrix)	11/5/15	GSK		IM	R Upper Arm L Lower Thigh	
	DTaP/HBV/IPV (Pediarix)	11/5/15	GSK		IM	R Upper Arm L Lower Thigh	
	Hep A (Hepatitis) 0.5 ml 1 ml	07/20/16	GSK		IM	R Upper Arm L Lower Thigh	
	Hep B (Hepatitis B) 0.5ml 1 ml	07/20/16	GSK		IM	R Upper Arm L Lower Thigh	
	Hib (Haemophilus influenzae B)	11/5/15	MSD		IM	R Upper Arm L Lower Thigh	
	HPV-9 Human Papillomavirus	12/2/16	MSD		IM	R Upper Arm L Lower Thigh	
	Influenza Inj 0.25ml 0.5 ml [redacted]	8/7/15	SFP		IM IN	R Upper Arm L Lower Thigh	
	IPV (Polio)	07/20/16	SFP		IM	R Upper Arm L Lower Thigh	
	MMR (Measles-Mumps-Rubella)	02/12/18	MSD		SQ	R Upper Arm L Lower Thigh	
	MCV-4 (Meningococcal Conjugate)	3/31/16	GSK		IM	R Upper Arm L Lower Thigh	
	PCV-13 (Pneumococcal Conjugate) PPSV23(polysaccharide pneumonia)	11/5/15 4/24/15	WAL MSD		IM IM	R Upper Arm L Lower Thigh	
	Men-B (Meningococcal group B)	8/9/16	WAL		IM	R Upper Arm L Lower Thigh	
	Rotavirus	2/23/18	MSD		PO	Oral	
	Td (tetanus-diphtheria)	4/11/17	SFP		IM	R Upper Arm L Lower Thigh	
	Tdap (tetanus-diphtheria-pertussis)	2/24/15	SFP GSK		IM	R Upper Arm L Lower Thigh	
	Varicella (chickenpox)	2/12/18	MSD		SQ	R Upper Arm L Lower Thigh	
	TwinRix (Hep A&B)	7/20/16	MSD		SQ	R Upper Arm L Lower Thigh	

1. Route: IM = Intramuscular, SQ = Subcutaneous, IN = Intransasal, PO = Oral
2. Manufacturer: SFP = sanofi Pasteur, GSK = GlaxoSmithKline, MSD = Merck & Co., WAL = Wyeth, MB=Mass Biologics
3. Site Vaccine Given: LA = Left Arm, RA = Right Arm, LT = Left Thigh, RT = Right Thigh
4. Exemption or Contraindication: MED = Medical, REG = Religious, PHIL = Philosophical, MOR = Moral, HOD = History of Disease (Please indicate date of exemption, contraindication or disease)

*Exemption or Contraindication Note