# VACCINE ADMINISTRATION RECORD
## Foster County Public Health
### FLU SERIES

881 Main Street, Carrington, ND 58421
(701) 652-3087

| NDIIS Provider 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**______________________

Name Of Insurance Company ________________________________ State of Insurance__________________________

Policy Holder *Last Name:________________________________ Policy Holder First Name________________________ Policy Holder Middle Initial__________

Policy Holder Date of Birth: _______________ Policy Holder Relationship to Client: _____________________ Policy Holder Address same as Patient? Yes☐ No☐

**(If no see reverse)**

*Policy Number:________________________________ Group Number if Applicable:___________________________

### Screening Questions for person getting vaccinated

| Question | Response |
|---|---|
| Are you sick today? | ☐YES ☐NO ☐DON'T KNOW |
| Do you have allergies to medications, food, a vaccine component or latex? List: | ☐YES ☐NO ☐DON'T KNOW |
| Have you ever had a serious reaction after receiving a vaccination? | ☐YES ☐NO ☐DON'T KNOW |
| Do you have a long-term health problem with heart disease, lung disease, (e.g., asthma), kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), anemia or another blood disorder? | ☐YES ☐NO ☐DON'T KNOW |
| Do you have cancer, leukemia, HIV/AIDS or any other immune system problem? | ☐YES ☐NO ☐DON'T KNOW |
| Have you had a seizure, brain or other nervous system problems including Guillain-Barre (paralyzing polio)? | ☐YES ☐NO ☐DON'T KNOW |
| During the past year, have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug? | ☐YES ☐NO ☐DON'T KNOW |
| For women: Are you pregnant or is there a chance you could become pregnant during the next month? | ☐YES ☐NO ☐DON'T KNOW |
| Have you received any vaccinations in the past 4 weeks? | ☐YES ☐NO ☐DON'T KNOW |
| Have you had shingles within the last year? | ☐YES ☐NO ☐DON'T KNOW |
| In the past 3 months, have you taken medication that affects your immune system such as prednisone, other steroids, or drugs for the treatment of cancer, rheumatoid arthritis, Crohn's disease, psoriasis or had radiation treatment? | ☐YES ☐NO ☐DON'T KNOW |
| Do you currently smoke, chew, vape or have exposure to secondhand smoke? | ☐YES ☐NO ☐DON'T KNOW |
| Are you a prior ☐smoker, ☐chewer, ☐electronic nicotine user/vape/JUUL? Quit date: _______________ Quitline Referral Accepted Yes☐ N/A☐ Referral Refused ☐ | ☐YES ☐NO ☐DON'T KNOW |

**(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) (VIS) 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). ☐ Patient refused VIS

______ 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** **REV:10/3//2019**

FLU SERIES **Race**______________ **Ethnicity**___________ **Birth State**______________________

Foster County Public Health
881 Main Street, Carrington, ND 58421
701) 652-3087 **Emergency Contact:**

NDIIS Provider 46 Name______________________ Phone________________ Relationship___________________

Patient Name_____________________________________________

# INSURANCE INFORMATION

**Address of Insurance Card Holder:** ___________________________________________

**City**________________________________________ **State** ________**Zip Code**___________ **Phone #:** ________________

**Relationship to Policy Holder (please circle)**: Self Spouse Child Other

# FOR PATIENTS UNDER 18 – PLEASE COMPLETE THE FOLLOWING

**Father's Name:**_________________________________________________________________

**Father's Date of Birth:** ____/____/_____ **Father's Phone Number:**_____________________________________

**Address (if different than minor):** _______________________________________________________

**Mother's Name:** ___________________________________________**Mother's Date of Birth:** ____/____/____

**Mother's Phone Number:** ____________________________ **Mother's Maiden Name**:_________________________

**Address (if different than minor):** _______________________________________________________

**Date/Time Vaccine Administered:** ☐ **Patient did not wait 15 minutes**

| X | Vaccine(s) To Be Given | VIS Date | Manu-facturer | Lot Number | Route | Administration Site | Nurse Signature |
|---|---|---|---|---|---|---|---|
| | Flulaval (MDV) Private 0.25ML 0.5ML | 08/15/19 | GSK | | IM | R Upper Arm<br>L Lower Thigh | |
| | Fluzone (MDV) Private 0.25ML 0.5ML | 08/15/19 | SFP | | IM | R Upper Arm<br>L Lower Thigh | |
| | Fluzone-PFS Private 0.5ML | 08/15/19 | SFP | | IM | R Upper Arm<br>L Lower Thigh | |
| | Flucelvax-PFS VFC 0.5ML **4YR & UP** | 08/15/19 | Seqirus | | IM | R Upper Arm<br>L Lower Thigh | |
| | Flucelvax-PFS 317 0.5ML **ADULT 19+** | 08/15/19 | Seqirus | | IM | R Upper Arm<br>L Lower Thigh | |
| | Fluzone (MDV) VFC 0.25ML 0.5ML | 08/15/19 | SFP | | IM | R Upper Arm<br>L Lower Thigh | |
| | **Medicare** 65+ Fluzone MDV 0.5ML | 08/15/19 | SFP | | IM | R Upper Arm<br>L Lower Thigh | |
| | | | | | | | |

**Date/Time Vaccine Administered:** ☐ **Patient did not wait 15 minutes**

| X | Vaccine(s) To Be Given | VIS Date | Manu-facturer | Lot Number | Route | Administration Site | Nurse Signature |
|---|---|---|---|---|---|---|---|
| | Flulaval (MDV) Private 0.25ML 0.5ML | 08/15/19 | GSK | | IM | R Upper Arm<br>L Lower Thigh | |
| | Fluzone (MDV) Private 0.25ML 0.5ML | 08/15/19 | SFP | | IM | R Upper Arm<br>L Lower Thigh | |
| | Fluzone-PFS Private 0.5ML | 08/15/19 | SFP | | IM | R Upper Arm<br>L Lower Thigh | |
| | Flucelvax-PFS VFC 0.5ML **4YR & UP** | 08/15/19 | Seqirus | | IM | R Upper Arm<br>L Lower Thigh | |
| | Flucelvax-PFS 317 0.5ML **ADULT 19+** | 08/15/19 | Seqirus | | IM | R Upper Arm<br>L Lower Thigh | |
| | Fluzone (MDV) VFC 0.25ML 0.5ML | 08/15/19 | SFP | | IM | R Upper Arm<br>L Lower Thigh | |
| | **Medicare** 65+ Fluzone MDV 0.5ML | 08/15/19 | SFP | | IM | R Upper Arm<br>L Lower Thigh | |
| | | | | | | | |

1. Route: IM = Intramuscular, SQ = Subcutaneous, IN = Intranasal, PO = Oral
2. Manufacturer: SFP = Sanofi Pasteur, GSK = GlaxoSmithKline, MSD = Merck & Co., WAL = Wyeth, MB=Mass Biologics **REV: 10/3//19**
3. Site Vaccine Given: R = Right, L = Left
4. Presentation: PFS=Prefilled Syringe, MDV=Multidose vial
5. Origin: VFC=Vaccine for children, 317=Uninsured & Underinsured adults
6. Exemption or Contraindication: MED = Medical, REL = Religious, PBE = Philosophical/ Moral, HD = History of Disease **(See Refusal to Vaccinate Form)**