NELSON-GRIGGS DISTRICT HEALTH UNIT VACCINE ADMINISTRATION RECORD

PO Box 365, McVille, ND 58254, Phone: (701) 322-5624, Fax: (701) 322-5111

Print Patient's Name (Last, First, Middle):	Date of Birth:	Age:	School & Grade: (If Applicable)	Gender: ☐ M ☐ F
Mother's First and Last Name:	Hispanic/Non-Hispanic:	Race:	Birth State or Country:	

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:

VFC Eligibility Status (Check all that apply):
☐ **Medicaid Eligible – Enter Number**_____
☐ Native American ☐ No Insurance ☐ Underinsured (Vaccines not covered by health insurance)
☐ Insured (Vaccines covered by health insurance – Not VFC eligible)

Please complete Primary Insurance section below and Secondary Insurance section if you have secondary insurance.

PRIMARY POLICY HOLDER INFORMATION

*__Last Name:__**_____ First Name_____ Middle Initial_____

Date of Birth:_____ Gender ☐ Male ☐ Female Policy Holder Relationship to Client: _____

Insurance Company Name and Address:_____

_____
(City) (State) (Zip)

***Policy Number:**_____ Group Number if Applicable:_____

SECONDARY POLICY HOLDER INFORMATION

*__Last Name:__**_____ First Name_____ Middle Initial_____

Date of Birth:_____ Gender ☐ Male ☐ Female Policy Holder Relationship to Client: _____

Insurance Company Name and Address:_____

_____
(City) (State) (Zip)

***Policy Number**:_____ Group Number if Applicable:_____

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.

(Please initial) ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

_____ I acknowledge that I have been provided with the Local Public Health Unit's Notice of Privacy Practices. I understand I may request an additional copy of the Notice at future contacts with this Local Public Health Unit.

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

_____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.

X_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PERSON **DATE**

VACCINE ADMINISTRATION RECORD

Nurse's Screening Questions

Healthy today?	**YES**	**NO**	**COMMENT**	
Allergies, esp. to eggs, gelatin, latex or Neomycin?	**YES**	**NO**	**COMMENT**	
Previous reactions to shots?	**YES**	**NO**	**COMMENT**	
Seizure disorders?	**YES**	**NO**	**COMMENT**	
Do you have cancer, leukemia of other immune system problems?	**YES**	**NO**	**COMMENT**	
Are you on ≥Prednisone 20mg, other steroids or radiation therapy?	**YES**	**NO**	**COMMENT**	
Pregnant?	**YES**	**NO**	**COMMENT**	
1ST Flu **or** Pneumonia Shot ever?	**YES**	**NO**	**COMMENT**	
Tobacco User OR Exposed to SHS?	**YES**	**NO**	**COMMENT**	**Refer to Quit Line**
Have you received any vaccinations in the past 4 wks?	**YES**	**NO**	**COMMENT**	

Date Vaccine Administered:

✓	Vaccine(s) To Be Given	VIS Date	Mfr. (circle)	Lot Number	Route	Admin. Site (circle)	Nurse Signature
	DTaP (Diphtheria-Tetanus-Pertussis)	05/17/07 11/05/15	AVP GSK		IM	LA RA LT RT	
	DTaP/IPV (Kinrix)	05/17/07 07/20/16	GSK		IM	LA RA LT RT	
	DTaP/IPV/HBV (Pediarix)	05/17/07 07/20/16 07/20/16	GSK		IM	LA RA LT RT	
	Hep A (Hepatitis A)	07/20/16	MSD GSK		IM	LA RA LT RT	
	Hep B (Hepatitis B)	07/20/16 11/05/15	GSK MSD		IM	LA RA LT RT	
	Hep A/Hep B (Twinrix)	07/20/16 07/20/16	GSK		IM	LA RA LT RT	
	Hib (Haemophilus Influenzae B)	04/02/15 11/05/15	AVP MSD		IM	LA RA LT RT	
	HPV-9 (Human Papillomavirus)	12/02/16	MSD		IM	LA RA LT RT	
	Influenza (6-35 months) Fluzone (Pediatric)	08/07/15	AVP		IM	LA RA LT RT	
	Influenza (6 months-adult) Fluzone	08/07/15	AVP		IM	LA RA LT RT	
	Influenza (6 months-adult) FluLaval	08/07/15	GSK		IM	LA RA LT RT	
	IPV (Inactivated Polio Vaccine)	07/20/16 11/05/15	AVP		IM/SQ	LA RA LT RT	
	MMR (Measles-Mumps-Rubella)	04/20/12	MSD		SQ	LA RA LT RT	
	MMRV (ProQuad)	05/21/10	MSD		SQ	LA RA LT RT	
	MCV-4 (Meningococcal Conjugate)	03/31/16	AVP		IM	LA RA LT RT	
	PCV-13 (Pneumococcal Conjugate)	11/05/15	WAL		IM	LA RA LT RT	
	PPV23 (Pneumococcal Polysaccharide)	04/24/15	MSD		IM/SQ	LA RA LT RT	
	Rotavirus	04/15/15	MSD		PO		
	Zostavax (Shingles)	10/06/09	MSD		SQ	LA RA	
	Td (Tetanus-Diphtheria)	04/11/17	AVP MassBio		IM	LA RA LT RT	
	Tdap (Tetanus-Diphtheria-Pertussis)	02/24/15	AVP GSK		IM	LA RA LT RT	
	Varicella (Chickenpox)	03/13/08	MSD		SQ	LA RA LT RT	

1. Route: IM = Intramuscular, SQ = Subcutaneous, IN = Intranasal, PO = Oral 2. Manufacturer: AVP = Sanofi Pasteur (Aventis), GSK = GlaxoSmithKline, MSD = Merck & Co., WAL = Wyeth, MassBio. = MassBiologics 3. Site Vaccine Given: LA = Left Arm, RA = Right Arm, LT = Left Thigh, RT = Right Thigh (09.17)