

NELSON-GRIGGS DISTRICT HEALTH UNIT VACCINE ADMINISTRATION RECORD

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

Client's Legal Name (Last, First, Middle):	Date Of Birth:	Age:	School & Grade: (If Applicable)	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Hispanic Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No	Race:
(If Client Is Age 18 Or Younger) Mother's Name:		Preferred Name (If Different from Legal Name):			Preferred Pronoun	
Mailing Address			City:	State:	Zip Code:	
Primary Phone #:			Secondary Phone #:			
Check All That Apply: <input type="checkbox"/> Health Insurance (Not VFC Eligible) <input type="checkbox"/> Medicaid Eligible <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> No Insurance <input type="checkbox"/> Underinsured				Birth State or Country (If Not USA):		
Primary Insurance Company Name (Example: Medicare)			Primary Insurance ID Number (Policy Number)			

PLEASE ANSWER THE QUESTIONS BELOW FOR THE PERSON RECEIVING VACCINE. Check Yes or No

Does the client have a long-term health problem with heart, lung (including asthma), kidney, liver, nervous system, or metabolic disease (e.g., diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are they taking regular aspirin or salicylate medication? Are they on long-term aspirin therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the client ever been diagnosed with a heart condition (myocarditis or pericarditis) or have they had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the client, a sibling, or a parent had a seizure; has the client had a brain or other nervous system problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client have an immune-system problem such as cancer, leukemia, HIV/AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the past 6 months, has the client taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have they had radiation treatments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client's parent or sibling have an immune system problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the past year, has the client received immune (gamma) globulin, blood/blood products, or an antiviral drug?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the client sick today?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the client received any vaccinations in the past 4 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the client anxious about getting a shot today?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client use tobacco or e-cigarettes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For babies: Have you ever been told the child had intussusception?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the client pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the client ever had a serious reaction to a vaccine in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the client ever felt dizzy or faint before, during, or after a shot?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the client exposed to secondhand smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, would you like to be referred to NDQuits?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For children age 2 through 4 years: Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS (Please read and sign below)

I acknowledge that I have been provided with Nelson-Griggs District Health Unit's Notice of Privacy Practices. I understand I may request an additional copy of the Notice at future contacts with Nelson-Griggs District Health Unit.

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

I authorize the release of any medical or other information necessary to process this claim. 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 Nelson-Griggs District 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 Nelson-Griggs District Health Unit of all benefits payable for the Client's care. 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.



Public Health
Prevent. Promote. Protect.
Nelson-Griggs
District Health Unit

Signature of Client or Person Authorized to Sign on the Client's Behalf:	Date:
---	--------------

NGDHU OFFICE USE ONLY:		Date Vaccine Administered:							
√	Vaccine(s) To Be Given	VIS / EUA Date	Lot Number	Vaccine Expiration	Mfr.	Dose Volume	Route ¹	Admin. Site ² (circle)	Nurse Signature ³
	COVID-19 (SPIKEVAX)	01/31/25			MOD	0.25 mL 0.5 mL	IM	LA RA LT RT	
	DTaP (Daptacel)	08/06/21, 07/24/23			SP	0.5 mL	IM	LA RA LT RT	
	DTaP/IPV (Kinrix)	08/06/21, 01/31/25			GSK	0.5 mL	IM	LA RA LT RT	
	DTaP/IPV/Hib (Pentacel)	08/06/21, 01/31/25, 08/06/21, 07/24/23			SP	0.5 mL	IM	LA RA LT RT	
	DTaP/IPV/Hib/HepB (Vaxelis)	08/06/21, 08/06/21, 08/06/21, 05/12/23, 07/24/23			MSD	0.5 mL	IM	LA RA LT RT	
	Hep A Pediatric (Havrix) (12 mos-18yrs)	01/31/25			GSK	0.5 mL	IM	LA RA LT RT	
	Hepatitis A Adult (Havrix) (19 yrs & over)	01/31/25			GSK	1.0 mL	IM	LA RA	
	Hepatitis B Pediatric (Engerix-B) (0-19 yrs)	01/31/25, 07/24/23			GSK	0.5 mL	IM	LA RA LT RT	
	Hepatitis B Adult (Engerix-B) (20 yrs & over)	01/31/25			GSK	1.0 mL	IM	LA RA	
	Hepatitis B Adult (HEPLISAV-B) (18 yrs & over)	01/31/25			DVAX	1.0 mL	IM	LA RA	
	Hib (ActHIB)	08/06/21, 07/24/23			SP	0.5 mL	IM	LA RA LT RT	
	HPV-9 (Gardasil9)	08/06/21			MSD	0.5 mL	IM	LA RA LT RT	
	Influenza (Fluzone)	01/31/25			SP	0.5 mL	IM	LA RA LT RT	
	Influenza (FluLaval)	01/31/25			GSK	0.5 mL	IM	LA RA LT RT	
	Influenza (Fluzone High Dose)	01/31/25			SP	0.5 mL	IM	LA RA	
	Influenza (Flucelvax)	01/31/25			Seqirus	0.5 mL	IM	LA RA	
	IPV (IPOL)	01/31/25, 07/24/23			SP	0.5 mL	IM/SQ	LA RA LT RT	
	MMR (MMR II)	01/31/25			MSD	0.5 mL	IM/SQ	LA RA LT RT	
	MMRV (ProQuad)	01/31/25			MSD	0.5 mL	IM/SQ	LA RA LT RT	
	MCV4 (MenQuadfi)	01/31/25			SP	0.5 mL	IM	LA RA LT RT	
	MenB (Bexsero)	01/31/25			GSK	0.5 mL	IM	LA RA LT RT	
	PCV20 (Prenar20) (Pneumococcal Conjugate)	05/29/25, 07/24/23			PFR	0.5 mL	IM	LA RA LT RT	
	Rotavirus (RotaTeq)	10/15/21			MSD	2.0 mL	PO		
	RSV (Abrysvo)	01/31/25			PFR	0.5 mL	IM	LA RA LT RT	
	Tdap (Boostrix)	01/31/25			GSK	0.5 mL	IM	LA RA LT RT	
	Varicella (Chickenpox)	01/31/25			MSD	0.5 mL	IM/SQ	LA RA LT RT	
	Zoster, Shingles (Shingrix)	02/04/22			GSK	0.5 mL	IM	LA RA	

1. Route: IM = Intramuscular, SQ = Subcutaneous, PO = Oral

2. Manufacturer: SP= Sanofi Pasteur, GSK = GlaxoSmithKline, MSD = Merck & Co., PFR = Pfizer, MOD = Moderna, DVAX = Dynavax

3. Site Vaccine Given: LA = Left Arm, RA = Right Arm, LT = Left Thigh, RT = Right Thigh