NELSON-GRIGGS DISTRICT HEALTH UNIT VACCINE ADMINISTRATION RECORD

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

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.

Client's Legal Name (Last, First, Middle):	Date Of Birth:	Age:	School & Grade: **(If Applicable)**	Gender: ☐ M ☐ F
Preferred Name **(If Different from Legal Name)**:		Preferred Pronoun:		
(If Client Is Age 18 Or Younger) Mother's Name:	Hispanic Origin: □ Yes □ No	Race:	Birth State or Country (If Not USA):	
Mailing Address:	City:	State:	Zip Code:	
Primary Phone #:	Secondary Phone #:			
Name Of Responsible Financial Party:	Address of Responsible Financial Party If Different from Client's Address:			

Vaccines for Children (VFC) Eligibility Status (Check All That Apply):
☐ Health Insurance (Not VFC Eligible) ☐ Medicaid Eligible ☐ Native American/Alaskan Native ☐ No Insurance ☐ Underinsured

Primary Insurance Company Name (Example: Medicare)	Primary Insurance ID Number (Policy Number)	Primary Insurance Group # **(If Applicable)**

Cash Paid:	Check Number:	Check Amount:	Bill To:	Receipt Needed?

PLEASE ANSWER THE QUESTIONS BELOW FOR THE PERSON RECEIVING VACCINE.	***Check Yes or No***
Is the client sick today?	□ **Yes** □ **No**
Does the client have allergies to medications, food, a vaccine component, or latex?	□ **Yes** □ **No**
Has the client had a serious reaction to a vaccine in the past?	□ **Yes** □ **No**
Has the client had a health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), asthma, or a blood disorder?	□ **Yes** □ **No**
Children only: child on long-term aspirin therapy? *Babies only*: has baby had intussusception (bowel obstruction)?	□ **Yes** □ **No**
Has the client, a sibling, or parent had a seizure; has the client had brain or other nervous system problems or Guillain-Barre (paralyzing polio)?	□ **Yes** □ **No**
Does the client have cancer, leukemia, HIV/AIDS, or any other immune system problems?	□ **Yes** □ **No**
In the past 3 months, has the client taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis or had radiation treatments?	□ **Yes** □ **No**
In the past year, has the client received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	□ **Yes** □ **No**
Has the client had myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining outside the heart)?	□ **Yes** □ **No**
Is the client pregnant or is there a chance client could become pregnant during the next month?	□ **Yes** □ **No**
Has the client received vaccinations in the past 4 weeks?	□ **Yes** □ **No**
Does the client use Tobacco or e-cigarettes?	□ **Yes** □ **No**
Is the client exposed to secondhand smoke?	□ **Yes** □ **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.

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/Moderna)	09/11/23 10/19/23			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 08/06/21			GSK	0.5 mL	IM	LA RA LT RT	
	DTaP/IPV/Hib (Pentacel)	08/06/21 08/06/21 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)	10/15/21			GSK	0.5 mL	IM	LA RA LT RT	
	Hepatitis A Adult (Havrix) (19 yrs & over)	10/15/21			GSK	1.0 mL	IM	LA RA	
	Hepatitis B Pediatric (Engerix-B) (0-19 yrs)	05/12/23 07/24/23			GSK	0.5 mL	IM	LA RA LT RT	
	Hepatitis B Adult (HEPLISAV-B) (18 yrs & over)	05/12/23			DVAX	1.0 mL	IM	LA RA	
	Hepatitis B Adult (Engerix-B) (20 yrs & over)	05/12/23			GSK	1.0 mL	IM	LA RA	
	HepA/HepB (Twinrix)	10/15/21 05/12/23			GSK	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)	08/06/21			SP	0.5 mL	IM	LA RA LT RT	
	Influenza (FluLaval)	08/06/21			GSK	0.5 mL	IM	LA RA LT RT	
	Influenza (Fluzone High Dose)	08/06/21			SP	0.5 mL	IM	LA RA	
	Influenza (Flucelvax)	08/06/21			Seqirus	0.5 mL	IM	LA RA	
	IPV (IPOL)	08/06/21 07/24/23			SP	0.5 mL	IM/SQ	LA RA LT RT	
	MMR (MMR II)	08/06/21			MSD	0.5 mL	IM/SQ	LA RA LT RT	
	MMRV (ProQuad)	08/06/21			MSD	0.5 mL	IM/SQ	LA RA LT RT	
	MCV4 (MenQuadfi)	08/06/21			SP	0.5 mL	IM	LA RA LT RT	
	MenB (Bexsero)	08/06/21			GSK	0.5 mL	IM	LA RA LT RT	
	PCV20 (Prevnar20) (Pneumococcal Conjugate)	05/12/23 07/24/23			PFR	0.5 mL	IM	LA RA LT RT	
	Rotavirus (RotaTeq)	10/15/21			MSD	2.0 mL	PO		
	RSV (Arexvy)	10/19/23			GSK	0.5 mL	IM	LA RA LT RT	
	Tdap (Boostrix)	08/06/21			GSK	0.5 mL	IM	LA RA LT RT	
	Varicella (Chickenpox)	08/06/21			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 = Dynava
3. Site Vaccine Given: LA = Left Arm, RA = Right Arm, LT = Left Thigh, RT = Right Thigh

Revised: 08.16.24