CAVALIER COUNTY HEALTH DISTRICT VACCINE ADMINSTRATION RECORD

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Tax ID Number: 45-0427926 NPI Number: 1174566335

THESE QUESTIONS ARE TO BE ANSWERED BY THE PERSON RECEIVING THE VACCINE OR PARENT/GUARDIAN MAKING THE REQUEST.

Questions 1-4 are used to determine if children 18 years of age or younger qualify for a federally funded immunization program titled Vaccine for Children (VFC).

□ Yes □ No **1.** Is your child enrolled in Medicaid?
□ Yes □ No **2.** Does your child have private health insurance that covers vaccinations?
□ Yes □ No **3.** Is your child Native American or Alaskan Native?

Client's Name (Last, First, Middle Initial):	**Date of Birth:**	**Age:**	**Male**	**Female**

Address (Street or P.O. Box):	**City:**	**State:**	**Zip Code:**	**Phone Number:**

ND Medicaid Number:	**Insurance Policy Number:**	**Medicare Part B Number:**

Name of Policy Holder:	**Date of Birth:**	**Address if different from above:**	**Relationship to Client:**

MEDICARE PATIENTS: PLEASE NOTIFY CCHD IF YOU HAVE AN ADVANTAGE PLAN

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

I acknowledge that I have been provided with Cavalier County Health District's Notice of Privacy Practices. I understand I may request an additional copy of the Notice at future contacts with Cavalier County Public Health.

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).

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 Cavalier County Health District'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 Cavalier County Health District of all benefits payable for the Client's care.

SCREENING QUESTIONS - DOES THE PERSON RECEIVING THE VACCINE:

□ Yes □ No **1)** Person receiving vaccine sick today?
□ Yes □ No **2)** Allergies to medications, injectables, food, a vaccine component, or latex?
Please list any allergies:_____
□ Yes □ No **3)** Serious reaction after receiving a previous vaccine?
□ Yes □ No **4)** Have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), Guillain-Barré syndrome, solid organ transplant, anemia, or other blood disorder? (Child on long-term aspirin therapy?)
□ Yes □ No **5)** Infants only - Has infant ever been told they have had intussusception?
□ Yes □ No **6)** Have cancer, leukemia, HIV/AIDS, or any other immune system problem?
□ Yes □ No **7)** In the past 3 months, has taken medications that affect the immune system, such as prednisone, other steroids, or anticancer drugs; drugs for treatment of rheumatoid arthritis, Crohn's disease, psoriasis, or had radiation treatments?
□ Yes □ No **8)** Have had a seizure or brain or other nervous system problem?
□ Yes □ No **9)** During the past year has received a transfusion of blood or blood products, or been given immune (gamma) globulin, or an antiviral drug?
□ Yes □ No **10)** For Females - Pregnant or chance of becoming pregnant in the next month?
□ Yes □ No **11)** Have received any vaccinations in the past 4 weeks?
□ Yes □ No **12)** Do you currently use tobacco?
□ Yes □ No **13)** If no, are you exposed to secondhand smoke?

Information collected on this form will be used to document authorization for receipt of vaccine(s). Information may be shared through the North Dakota Immunization Information System (NDIIS) with other entities in accordance with the ND Century Code 23-01-05.3.

Signature of Person to receive vaccine or person authorized to sign on the client's behalf:	**Date:**
Printed Signature and Relationship to Client:	

Office Use Only

Vaccine(s) To Be Given	Route	VIS Date	MGF (Circle)	Lot Number	S/P[1]	Admin Site[2]	Vaccine Administrator
DTaP	IM	8/6/21	GSK				
DTaP-IPV	IM	8/6/21 8/6/21	GSK				
DTaP/HIB/IPV	IM	8/6/21 8/6/21 8/6/21	Sanofi				
DTaP/IPV/Hib/HepB	IM	8/6/21 8/6/21 8/6/21 5/12/23	Sanofi				
Hep A (2 doses) ped - 12 mos-18 yrs	IM	10/15/21	GSK				
Hep A adult – 19yrs+	IM	10/15/21	GSK				
Hep B (PF) ped - 0-19 yrs	IM	5/12/23	GSK				
Hep B adult - 20 yrs & over	IM	5/12/23	GSK				
Hib	IM	8/6/21	Sanofi				
HPV-9	IM	8/6/21	Merck				
IPV	IM/SQ	8/6/21	Sanofi				
MMR	SQ	8/6/21	Merck				
MCV4 (Meningococcal)	IM	8/6/21	Sanofi				
MenB	IM	8/6/21	GSK				
PCV20 Pneumococcal (conjugate)	IM	5/12/23	Pfizer				
Rotavirus	PO	10/15/21	Merck				
RSV (Respiratory Syncytial Virus) Adult	IM	7/24/23	Pfizer GSK				
RSV (Respiratory Syncytial Virus) Infant Beyfortus	IM	9/25/23	Sanofi				
Tdap	IM	8/6/21	Sanofi				
Varicella (Chickenpox)	SQ	8/6/21	Merck				
Zoster (Recombinant) Shingles	IM	2/4/22	GSK				
Influenza - Inactivated (IIV)	IM	8/6/21	GSK Sanofi Sanofi – HD Seqirus				
Influenza - Live, Intranasal (LAIV)	IN	8/6/21	AstraZeneca				
COVID-19	IM	10/19/23	Moderna Pfizer				

Assessment/Teaching: _____

Nurse's Signature **Date**

COMMENTS: (Include exemptions, contraindications, informed refusals and "Contact" vaccination information)

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