

CAVALIER COUNTY HEALTH DISTRICT VACCINE ADMINISTRATION 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 Unknown **1.** Is your child enrolled in Medicaid?
- Yes No Unknown **2.** Does your child have private health insurance?
- Yes No Unknown **3.** Does your child's private health insurance cover vaccinations?
- Yes No **4.** 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:	County:	State:	Zip Code:
Telephone Number:	* ND Medicaid Number:	*Insurance Policy Number:		Medicare Part B Number:	
Name of Policy Holder:		Date of Birth:	Address if different from client's address:		Relationship to Client:

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.** If receiving COVID-19 vaccine – have you received a dose of COVID-19 vaccine?
If yes, what brand? **Pfizer Moderna Other**_____
- Yes No **3.** Allergies to medications, injectables, food, a vaccine component or latex?
- Yes No **4.** Serious reaction after receiving a previous vaccine?
- Yes No **5.** Have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? (Child on long-term aspirin therapy?)
- Yes No **6.** (Infants only) – Has infant ever been told he or she has had intussusception?
- Yes No **7.** Have cancer, leukemia, HIV/AIDS, or any other immune system problem?
- Yes No **8.** 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 **9.** Have had a seizure or brain or other nervous system problem?
- Yes No **10.** 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 **11.** For Females – Pregnant or chance of becoming pregnant in the next month?
- Yes No **12.** Have received any vaccinations in the past 4 weeks?
- Yes No **13.** Do you currently use tobacco?
- Yes No **14.** 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- Person to receive vaccine or person authorized to sign on the client's behalf:	Date:
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*****Office Use Only*****

Vaccine(s) To Be Given	Route	VIS Date	MGF (Circle)	Lot Number	S/P ¹	Admin Site ²	Vaccine Administrator
DTaP (Tripedia) (Infranrix)	IM	8/6/21	GSK				
DTaP-IPV (Kinrix)	IM	8/6/21 8/6/21	GSK				
DTaP/HIB/IPV (Pentacel)	IM	8/6/21 8/6/21 8/6/21	Sanofi				
DTaP/IPV/Hib/HepB (Vaxelis)	IM	8/6/21 8/6/21 8/6/21 10/15/21	Sanofi				
Hep A (HAV 2 doses) ped - 12 mos-18 yrs	IM	10/15/21	GSK				
Hep A (HAV adult) 19 yrs & over	IM	10/15/21	GSK				
Hep B (Hep B preservative free) ped - 0-19 yrs	IM	10/15/21	GSK				
Hep B (HBV adult) 20 yrs & over	IM	10/15/21	GSK				
Hib (HbOC) ActHib (PRP-OMP) PedvaxHIB	IM	8/6/21	Sanofi				
HPV-9 (Gardasil) 9-26 yrs	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				
PCV13 Pneumococcal (conjugate) Prevnar	IM	2/4/22	Pfizer				
PCV20 Pneumococcal (conjugate) Prevnar	IM	2/4/22	Pfizer				
PPV23 Pneumococcal (polysaccharide) Pneumovax	IM/SQ	10/30/19	Merck				
Rotavirus (Rotateq)	PO	10/15/21	Merck				
Tdap (Adacel)	IM	8/6/21	Sanofi				
Varicella (Chickenpox)	SQ	8/6/21	Merck				
Zoster (Recombinant) Shingles, RZV	IM	2/4/22	GSK				
IIV (Inactivated Influenza Vaccine)	IM	8/6/21	GSK Sanofi Sanofi - HD Seqirus				
COVID-19	IM	EUA Varies	Moderna Pfizer Janssen Novavax				

Assessment/Teaching: _____

Nurse's Signature

Date

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

Billed to: _____

Amount Billed: _____

Date Billed: _____

Date Paid: _____