VACCINE ADMINISTRATION RECORD

NORTH DAKOTA DEPARTMENT OF HEALTH SFN 18385 (05-2018)

Provider ID: 40

Revised: 2-26-2019

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 North Dakota Century Code 23-01-05.3.

Patient's name: (Last, First, Middle)			Race: (Check box) ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White
Hispanic or Latino: (Circle) Yes No	Date of birth:	Age:	Gender (Circle): Male Female
Address: (Street or P.O. box)			

City:	State:	Zip code:	County:	Birth state or birth country (if not U.S.):

Primary telephone number:	Work telephone number:	E-mail address:

Mother's name (if patient is 18 years or younger): Last, First, Middle	Mother's maiden name (if patient is 18 years or younger):

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).

Signature – Person to receive vaccine or person authorized to sign on the patient's behalf:	Date:

VFC eligibility status: (Check all that apply)

☐ American Indian ☐ Medicaid-eligible ☐ No insurance ☐ Underinsured (vaccines not covered by health insurance)
☐ Not eligible (vaccines covered by health insurance) ☐ Other state eligible

THE FOLLOWING SCREENING QUESTIONS ARE TO DETERMINE IF YOUR CHILD IS WELL ENOUGH TO RECEIVE THE FLU SHOT TODAY. DOES YOUR CHILD-

Yes No **5.** have any problems after receiving previous vaccines?
Yes No **6.** have any allergies to latex, food, medicine, or any vaccine?
Yes No **7.** have a brain problem; ever had a seizure or Guillain-Barre' syndrome?
Yes No **8.** have a serious long-term health problem such as heart, lung, liver, or kidney disease, diabetes, etc.?
Yes No **9.** have any problems with his/her immune system, such as cancer, leukemia, or HIV/AIDS?
Yes No **10.** taken cortisone, prednisone, other steroids, anti-cancer drugs, or x-ray treatments in the past 3 months?
Yes No **11.** Is the child sick today?
Yes No **12.** Is the child pregnant or think she may be pregnant?
Yes No **13.** Received a previous does of seasonal flu vaccine? If so: 1 Dose 2 or more doses

Please list Policy and Group Numbers for all insurances you may have:

Medicare Part B Policy #:	Group # if listed:	Policy Holder Name and Date of birth:
Blue Cross Policy #:	Group # if listed:	Policy Holder Name and Date of birth:
ND Medical Assistance #:	Group # if listed:	Policy Holder Name and Date of birth:
Sanford Policy #:	Group # if listed:	Policy Holder Name and Date of birth:
Other Insurance-Name of Company and Policy #:	Group # if listed:	Policy Holder Name and Date of birth:

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✓	Vaccine(s) to be given	Route[1]	VIS date[2]	Manufacturer[3]	Lot number	S/P[4]	Admin. site[5]	Person admin.[6]
✓	Influenza	ID/IM/IN	8/15/19	GSK	M5325	P		

Exemption or contraindication[7]:	Date of exemption or contraindication:

Signature and title of person administering vaccine:	Date vaccine administered: