VACCINE ADMINISTRATION RECORD
Foster County Public Health
FLU SERIES

881 Main Street, Carrington, ND 58421
(701) 652-3087

NDIIS Provider Number
46

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.

Print Patient's Name (Last, First, Middle Initial):		Date of Birth:	Age:	Gender: ☐ Male ☐ Female
Address (Street or PO Box):	City:	County:	State:	Zip Code:
Home Phone #	Cell #	Work #		
Name of Responsible Financial Party:	Address if different from Patient's address:			

☐ **Native American** ☐ **Alaskan Native** ☐ **No Insurance** ☐ **Underinsured (Vaccines not covered by health insurance)**
☐ **Insured (Vaccines covered by health insurance – Not VFC eligible)** ☐ **Medicaid– Enter Number**_____

Name Of Insurance Company_____ State of Insurance_____

Policy Holder *Last Name:_____ Policy Holder First Name_____ Policy Holder Middle Initial_____

Policy Holder Date of Birth: _____ Policy Holder Relationship to Client: _____ Policy Holder Address same as Patient? Yes☐ No☐

(If no see reverse)

*Policy Number:_____ Group Number if Applicable:_____

Screening Questions for person getting vaccinated

Are you sick today?	☐YES ☐NO ☐DON'T KNOW
Do you have allergies to medications, food, a vaccine component, or latex? List:	☐YES ☐NO ☐DON'T KNOW
Have you ever had a serious reaction after receiving a vaccination?	☐YES ☐NO ☐DON'T KNOW
Do you have a long-term health problem with heart disease, lung disease, (e.g., asthma), kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), anemia or another blood disorder?	☐YES ☐NO ☐DON'T KNOW
Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐YES ☐NO ☐DON'T KNOW
Have you had a seizure, brain or other nervous system problems including Guillain-Barre (paralyzing polio)?	☐YES ☐NO ☐DON'T KNOW
During the past year, have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug?	☐YES ☐NO ☐DON'T KNOW
For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐YES ☐NO ☐DON'T KNOW
Have you received any vaccinations in the past 4 weeks?	☐YES ☐NO ☐DON'T KNOW
Have you had shingles within the last year?	☐YES ☐NO ☐DON'T KNOW
In the past 3 months, have you taken medication that affects your immune system such as prednisone, other steroids, or drugs for the treatment of cancer, rheumatoid arthritis, Crohn's disease, psoriasis or had radiation treatment?	☐YES ☐NO ☐DON'T KNOW
Do you currently smoke, chew, vape or have exposure to secondhand smoke?	☐YES ☐NO ☐DON'T KNOW
Are you a prior ☐smoker, ☐chewer, ☐electronic nicotine user/vape/JUUL? Quit date:_____ Quitline Referral Accepted Yes☐ N/A☐ Referral Refused ☐	☐YES ☐NO ☐DON'T KNOW

(Please initial) **ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS**

_____ I authorize the release of any medical or other information necessary to process this claim. I consent to data entry into the ND state registry.

_____ A copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Statement(s) (VIS) 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). Patient refused VIS ☐

_____ 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 the Local Public 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 the Local Public Health Unit of all benefits payable for the Client's care. (minor not allowed to sign)

X_____ _____ _____

Signature of patient or responsible person **relationship to patient** **date**

Vaccine Administration Record

Race_____ **Ethnicity**_____ **Birth State**_____

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Emergency Contact:

Name_____ Phone_____ Relationship_____

Patient Name_____

INSURANCE INFORMATION

Address of Insurance Card Holder: _____

City_____ **State**_____ **Zip Code**_____ **Phone #:**_____

Relationship to Policy Holder (please circle): Self Spouse Child Other

FOR PATIENTS UNDER 18 – PLEASE COMPLETE THE FOLLOWING

Father's Name:_____

Father's Date of Birth: ____/____/_____ **Father's Phone Number:**_____

Address (if different than minor): _____

Mother's Name: _____ **Mother's Date of Birth:** ____/____/____

Mother's Phone Number: _____ **Mother's Maiden Name:**_____

Address (if different than minor): _____

Date/Time Vaccine Administered: ☐ **Patient did not wait 15 minutes**

X	Vaccine(s) To Be Given	VIS Date	Manu-facturer	Lot Number	Route	Administration Site	Nurse Signature
	Medicare HD private 0.7ML				IM	R Upper Arm L Lower Thigh	
	Fluzone (MDV) Private 0.5ML	08/15/19	SFP		IM	R Upper Arm L Lower Thigh	
	Fluzone-PFS Private 0.5ML	08/15/19	SFP		IM	R Upper Arm L Lower Thigh	
	Flucelvax-PFS VFC 0.5ML	08/15/19	Seqirus		IM	R Upper Arm L Lower Thigh	
	Flucelvax-PFS 317 0.5ML **ADULT 19+**	08/15/19	Seqirus		IM	R Upper Arm L Lower Thigh	
	Fluzone (MDV) VFC 0.5ML	08/15/19	SFP		IM	R Upper Arm L Lower Thigh	
	Medicare 65+ Fluzone MDV 0.5ML	08/15/19	SFP		IM	R Upper Arm L Lower Thigh	

Date/Time Vaccine Administered: ☐ **Patient did not wait 15 minutes**

X	Vaccine(s) To Be Given	VIS Date	Manu-facturer	Lot Number	Route	Administration Site	Nurse Signature
					IM	R Upper Arm L Lower Thigh	
	Fluzone (MDV) Private 0.5ML	08/15/19	SFP		IM	R Upper Arm L Lower Thigh	
	Fluzone-PFS Private 0.5ML	08/15/19	SFP		IM	R Upper Arm L Lower Thigh	
	Flucelvax-PFS VFC 0.5ML	08/15/19	Seqirus		IM	R Upper Arm L Lower Thigh	
	Fluzone (MDV) VFC 0.25ML 0.5ML	08/15/19	SFP		IM	R Upper Arm L Lower Thigh	
	Medicare 65+ Fluzone MDV 0.5ML	08/15/19	SFP		IM	R Upper Arm L Lower Thigh	

1. Route: IM = Intramuscular, SQ = Subcutaneous, IN = Intranasal, PO = Oral
2. Manufacturer: SFP = Sanofi Pasteur, GSK = GlaxoSmithKline, MSD = Merck & Co., WAL = Wyeth, MB=Mass Biologics **REV: 09/09/2020**
3. Site Vaccine Given: R = Right, L = Left
4. Presentation: PFS=Prefilled Syringe, MDV=Multidose vial
5. Origin: VFC=Vaccine for children, 317=Uninsured & Underinsured adults
6. Exemption or Contraindication: MED = Medical, REL = Religious, PBE = Philosophical/ Moral, HD = History of Disease **(See Refusal to Vaccinate Form)**