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VACCINE ADMINISTRATION RECORD SERIES

Clinic Identification Number

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 Name):	Date of Birth:	Age:	Gender: ☐ Male ☐ Female Race:

Address (Street or PO Box):	City:	County:	State:	Zip Code:

Home Phone #	Cell #	Work #	Email Address

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Unknown	Birth State or Country	Mother's Name (Last, First, Middle, Maiden)

Name of Responsible Financial Party:	Address if different from Patient's address:

THESE QUESTIONS are used to determine if children 18 years of age or younger qualify for the federally funded immunization program titled Vaccine for Children (VFC)

☐ Yes ☐ No 1. Does you child have private health insurance?
___ No insurance ___ Under insured

☐ Yes ☐ No 2. Does your private health insurance cover immunization?

☐ Yes ☐ No 3. Is your child covered by Healthy Steps?

☐ Yes ☐ No 4. Is your child Native American or Alaskan Native?

☐ Yes ☐ No 5. Is your child covered by the Caring for Children Program?

☐ Yes ☐ No 6. Is your child enrolled in Medicaid?

Medicaid Number _____ **Is Medicaid:** ☐ Primary Insurance ☐ Secondary Insurance

Immunizations to be given:

☐ **MCV4** ☐ **Tdap** ☐ **Influenza**

☐ **Varicella (Chickenpox)**

☐ **HPV** ☐ **Hepatitis A**

BCBS PRIMARY POLICY HOLDER INFORMATION

***Last Name:** _____ First Name _____ Middle Name _____

Date of Birth: _____ Gender ☐ Male ☐ Female Policy Holder Relationship to Client: _____

***Policy Number**: _____ Group Number if Applicable: _____

BCBS SECONDARY POLICY HOLDER INFORMATION

***Last Name:** _____ First Name _____ Middle Name _____

Date of Birth: _____ Gender ☐ Male ☐ Female Policy Holder Relationship to Client: _____

***Policy Number**: _____ Group Number if Applicable: _____

SANFORD HEALTH POLICY HOLDER INFORMATION

***Last Name:** _____ First Name _____ Middle Name_____

Date of Birth: _____ Gender ☐ Male ☐ Female Policy Holder Relationship to Client: _____

Policy Number: _____

SANFORD HEALTH PATIENT'S INFORMATION

***Policy Number:** _____ Group Number if Applicable: _____

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

(***Please read the four paragraphs below and initial each)***

_____ I acknowledge that I have been provided with the Upper Missouri District Health Unit's Notice of Privacy Practices. I understand I may request an additional copy of the Notice at future contacts with Upper Missouri District Health Unit.

_____ I authorize the release of any medical or other information necessary to process this claim.

_____ 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). 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) checked on the reverse side be given to me or to the person named above (for whom I am authorized to make this request).

_____ If I am the Client, or an individual legally obligated to pay for immunization services provided to the Client or a Guarantor of payment, I agree to pay and I am financially responsible for the Upper Missouri 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 the Upper Missouri District Health Unit of all benefits payable for the Client's care.

X _____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PERSON **DATE**

VACCINE ADMINISTRATION RECORD SERIES					Date Vaccine Administered:			
√	VFC State 317-P	Vaccine(s) To Be Given	VIS Date	Mfr. (circle)	Lot Number	Route	Admin. Site (circle)	Nurse Signature
	VFC State P	Hep B (Hepatitis B)	02/02/12	GSK MSD		IM	LA RA LT RT	
	VFC State P	MMR (Measles-Mumps-Rubella) MMRV (MMR-Varicella)	04/20/12 05/21/10	MSD		SQ	LA RA LT RT	
	VFC State P	Varicella (chickenpox)	03/13/08	MSD		SQ	LA RA LT RT	
	VFC State P	Tdap (tetanus-diphtheria-pertussis)	05/09/13	AVP GSK		IM	LA RA LT RT	
	VFC State P	HPV-4 (Human Papillomavirus)	05/17/13	MSD		IM	LA RA LT RT	
	VFC State P	Hep A (Hepatitis A)	10/25/11	MSD GSK		IM	LA RA LT RT	
	VFC State P	MCV4 Menveo	10/14/11	Novartis		IM	LA RA LT RT	
	VFC State P	Influenza	08/07/15	GSK Medimmune		IM IN	LA RA LT RT	
Date Vaccine Administered:								
	VFC State P	Hep B (Hepatitis B)	02/02/12	GSK MSD		IM	LA RA LT RT	
	VFC State P	MMR (Measles-Mumps-Rubella) MMRV (MMR-Varicella)	04/20/12 05/21/10	MSD		SQ	LA RA LT RT	
	VFC State P	Varicella (chickenpox)	03/13/08	MSD		SQ	LA RA LT RT	
	VFC State P	Tdap (tetanus-diphtheria-pertussis)	05/19/13	AVP GSK		IM	LA RA LT RT	
	VFC State P	HPV-4 (Human Papillomavirus)	05/17/13	MSD		IM	LA RA LT RT	
	VFC State P	Hep A (Hepatitis A)	10/25/11	MSD GSK		IM	LA RA LT RT	
	VFC State P	MCV4 Menveo	10/14/11	Novartis		IM	LA RA LT RT	
	VFC State P	Influenza	08/07/15	GSK Medimmune		IM IN	LA RA LT RT	
Date Vaccine Administered:								
	VFC State P	Hep B (Hepatitis B)	02/02/12	GSK MSD		IM	LA RA LT RT	
	VFC State P	MMR (Measles-Mumps-Rubella) MMRV (MMR-Varicella)	04/20/12 05/21/10	MSD		SQ	LA RA LT RT	
	VFC State P	Varicella (chickenpox)	03/13/08	MSD		SQ	LA RA LT RT	
	VFC State P	Tdap (tetanus-diphtheria-pertussis)	05/19/13	AVP GSK		IM	LA RA LT RT	
	VFC State P	HPV-4 (Human Papillomavirus)	05/17/13	MSD		IM	LA RA LT RT	
	VFC State P	Hep A (Hepatitis A)	10/25/11	MSD GSK		IM	LA RA LT RT	
	VFC State P	MCV4 Menveo	10/14/11	Novartis		IM	LA RA LT RT	
	VFC State P	Influenza	08/07/15	GSK Medimmune		IM IN	LA RA LT RT	

1. Route: IM = Intramuscular, SQ = Subcutaneous, IN = Intranasal, PO = Oral 2. Manufacturer: AVP = Sanofi Pasteur (Aventis), GSK = GlaxoSmithKline, MSD = Merck & Co. 3. Site Vaccine Given: LA = Left Arm, RA = Right Arm, LT = Left Thigh, RT = Right Thigh