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VACCINE ADMINISTRATION RECORD

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:	Phone:

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 your child have private health insurance?
□ 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

BCBS ONLY PRIMARY POLICY HOLDER INFORMATION

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

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

Insurance Company Information: _____ _____
(Name) (Telephone Number)

_____
(Street/Mailing Address) (City) (State) (Zip)

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

BCBS ONLY SECONDARY POLICY HOLDER INFORMATION

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

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

Insurance Company Information: _____ _____
(Name) (Telephone Number)

_____
(Street/Mailing Address) (City) (State) (Zip)

***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**

***Office Verification** _____

VACCINE ADMINISTRATION RECORD				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	DTaP (diphtheria-tetanus-pertussis)	05/17/07 09/18/08	AVP GSK		IM	LA RA LT RT	
	VFC State	Pentacel (DtaP- ActHib-IPV)	05/17/07 12/16/98 11/8/11	AVP		IM	LA RA LT RT	
	VFC State	Kinrix (DtaP-IPV)	05/17/07 11/8/11	GSK		IM	LA RA LT RT	
	VFC State	DT	05/17/10	AVP		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	Hep B (Hepatitis B)	02/02/12 09/18/08	GSK MSD		IM	LA RA LT RT	
	State 317	Twinrix (Hep A/Hep B)	10/25/1102/ 2/12	GSK		IM	LA RA LT RT	
	VFC State	Hib (Haemophilus influenzae B)	12/16/98 09/18/08	AVP MSD		IM	LA RA LT RT	
	VFC State P	HPV-4 (Human Papillomavirus)	05/03/11	MSD		IM	LA RA LT RT	
	VFC State	Influenza (6-35 months) Fluzone	07/26/11	AVP		IM	LA RA LT RT	
	VFC State P	Influenza (3yrs – adult) Fluzone	07/26/11	AVP		IM	LA RA LT RT	
	VFC State P	Influenza (Intranasal) FluMist	07/26/11	MedImmune		IN		
	VFC State P	IPV (inactivated polio vaccine)	11/08/11 09/18/08	AVP		IM/SQ	LA RA LT RT	
	VFC State P	MMR (Measles-Mumps-Rubella)	4/20/12	MSD		SQ	LA RA LT RT	
	VFC State	MMRV (MMR-Varicella)	05/21/10	MSD		SQ	LA RA LT RT	
	VFC State P	MCV-4 (Meningococcal Conjugate)	10/14/11	AVP		IM	LA RA LT RT	
	VFC State	PCV-13 (Pneumococcal Conjugate)	04/16/10	WAL		IM	LA RA LT RT	
	VFC State	Rotavirus	12/6/10 09/18/08	GSK MSD		PO		
	VFC State P	Td (tetanus-diphtheria)	01/24/12	AVP MASS BIO GSK		IM	LA RA LT RT	
	VFC State P	Tdap (tetanus-diphtheria-pertussis)	01/24/12	AVP GSK		IM	LA RA LT RT	
	VFC State P	Varicella (chickenpox)	03/13/08	MSD		SQ	LA RA LT RT	
	P	Typhoid	05/19/04	AVP		IM	LA RA LT RT	
	P	Japanese Encephalitis	12/07/11	Novartis		SQ	LA RA LT RT	
	P	Rabies (pre-exposure)	10/06/09	AVP		IM	LA RA LT RT	
	P	Yellow Fever	03/30/11	AVP		SQ	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., WAL = Wyeth, MASS BIO = Massachusetts Biologic, 3. Site Vaccine Given: LA = Left Arm, RA = Right Arm, LT = Left Thigh, RT = Right Thigh