VACCINE ADMINISTRATION RECORD

Clinic Identification Number **48**

Public Health
Prevent. Promote. Protect.

Kidder County District Health Unit

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 #		
Hispanic or Latino: Yes No	Birth state or birth country (if not U.S.)	E-mail address:		

RACE: *(Check box)* ☐ Native Hawaiian or other Pacific Islander ☐ Black or African American ☐ Asian ☐ White ☐ American Indian or Alaskan Native ☐ Other

Mother's name (if patient is 18 yrs. or younger): **Last, First, Middle**

Mother's maiden name (if patient if 18 years or younger):

_____***ASK:*** Do you use any tobacco products? Y N
Cigarettes: Y N Cigars: Y N Hookah: Y N
Do you "vape" electronic cigarettes (e-cigs)? Y N
Do you chew/use smokeless tobacco? Y N
Are you exposed to second-hand smoke (SHS)? Y N

_____***ADVISE:*** As your health care provider, *I ADVISE you to QUIT* using tobacco products. They are dangerous to your health and the health of others.

_____***REFER:*** I am referring you to the North Dakota Quit Line. They can assist you in your efforts to quit using tobacco products, reduce tobacco exposure, and lead a healthier life. Here is a pamphlet to the ND Quit Line their toll free number 1-800-QUIT-NOW

VFC Eligibility Status - Check all that apply. THIS SECTION MUST BE COMPLETED FOR ALL CLILDREN YOUNGER THAN 19

☐ Medicaid Eligible **Medicaid Number**_____ ☐ American Indian ☐ No Insurance

☐ Underinsured (Vaccines **not covered** by health insurance) ☐ Not eligible -Vaccines **covered** by health insurance

INSURANCE INFORMATION

POLICY HOLDER INFORMATION

Last Name:_____ First Name:_____ Middle Initial:_____

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

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 Local Public Health Unit's Notice of Privacy Practices. I understand I may request an additional copy of the Notice at future contacts with this Local Public 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) 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)

_____ 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.

X_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PERSON **DATE**

Screening Checklist for Contraindications to HPV, MenACWY, MenB, and Tdap Vaccines for Teens

YOUR NAME_____

DATE OF BIRTH____/____/____
month day year

For parents/guardians: The following questions will help us determine if human papillomavirus (HPV), meningococcal conjugate (MenACWY), meningococcal serogroup B (MenB), and tetanus, diphtheria, and acellular pertussis (Tdap) vaccines may be given to your teen today. If you answer "yes" to any question, it does not necessarily mean your teen should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is your teen sick today?	☐	☐	☐
2. Does your teen have allergies to a vaccine component or to latex?	☐	☐	☐
3. Has your teen had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Has your teen had brain or other nervous system problems?	☐	☐	☐
5. For females: Is your teen pregnant?	☐	☐	☐

FORM COMPLETED BY_____ DATE_____

FORM REVIEWED BY_____ DATE_____

Did you bring your teen's immunization record card with you? yes ☐ no ☐

It is important to have a personal record of your teen's vaccinations. If you don't have one, ask your healthcare provider to give you one with all of your teen's vaccinations on it. Keep it in a safe place and be sure your teen carries it every time he/she seeks medical care. Your teen will likely need this document to enter school or college, for employment, or for international travel.

immunization action coalition
IAC
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4062.pdf • Item #P4062 (3/16)