



Public Health  
Prevent. Promote. Protect.

### CENTRAL VALLEY HEALTH DISTRICT VACCINE ADMINISTRATION RECORD (VAR)

122 Second Street NW, Jamestown ND 58401, Phone: (701) 252-8130  
Logan County Courthouse, 301 Broadway, Napoleon ND 58561 phone: (701)754-2756

Client's Name (Last, First, Middle Initial):		DOB:	Age:	Birth State:	Primary Phone Number:	
Address (Street or P.O. Box):		City:		County:	State:	Zip Code:
Name of Primary Insurance Company: BCBS MCB Medicaid Other: _____			Policy or ID Number:		Group # (if applies):	
Name of Policy Holder:		DOB of Policy Holder:	Address of Policy Holder:			
Name of Secondary Insurance Company: BCBS MCB Medicaid Other: _____			Policy or ID Number:		Group # (if applies):	

If client is under the age of 18, please complete the following:

Parent or Legal Guardian:	Relationship to Client:	Client's Mother's Maiden Name:
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Race: White	African American	Amer. Indian	Asian	Other	Hispanic Origin: Yes	No	Male	Female
Do you use tobacco products? Yes No				Are you exposed to second hand smoke? Yes No				

THESE QUESTIONS ARE TO BE ANSWERED BY THE PERSON RECEIVING THE VACCINE OR PARENT/GUARDIAN MAKING THE REQUEST.

Questions 1 – 4 are used to determine if children 18 years of age or younger qualify for a federally funded immunization program titled Vaccine for Children (VFC).

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|-----|----|---------|---|
| Yes | No | Unknown | 1. Is your child enrolled in Medicaid?                    |
| Yes | No | Unknown | 2. Does your child have health insurance?                 |
| Yes | No | Unknown | 3. Does your child's health insurance cover vaccinations? |
| Yes | No | Unknown | 4. Is your child Native American or Alaskan Native?       |

HAS OR DOES THE PERSON RECEIVING THE VACCINE:

- |     |    |   |
|-----|----|---|
| Yes | No | 5. had any problems after receiving previous vaccines?  |
| Yes | No | 6. have any allergies to food, medicine, or any vaccine?  |
| Yes | No | 7. have a brain problem or ever had a seizure?  |
| Yes | No | 8. have any problems with his/her immune system, such as cancer, leukemia, or HIV/AIDS?                       |
| Yes | No | 9. taken cortisone, prednisone, other steroids, anti-cancer drugs, or x-ray treatments in the past 3 months?  |
| Yes | No | 10. received any blood products or Immune Globulin in the past year?  |
| Yes | No | 11. had chickenpox? If yes, date of disease if known _____  |
| Yes | No | 12. received any vaccines in the past four weeks?   |
| Yes | No | 13. Is the person who is receiving the vaccine pregnant?  |
| Yes | No | 14. Is the person receiving the vaccine sick today?   |
| Yes | No | 15. Have read the <u>Vaccine Information Statement</u> about the vaccine you or your child will be receiving? |

MY SIGNATURE BELOW INDICATES:

- I have read, or have had explained, information about the vaccine(s) to be administered and the disease(s) for which they provide protection.
- There was an opportunity to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) cited and ask that the vaccine(s) listed below be given to me or the person named below (for whom I am authorized to make this request.)
- 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 the North Dakota Century Code 23-01-05.3.
- I acknowledge CVHD has provided me with their Notice of Privacy Practices. I understand I may request a copy of the Notice.
- I authorize the release of any medical or other information necessary to process this claim.
- If I am the client, or an individual legally obligated to pay for medical expenses provided to the client or a Guarantor of payment, I agree to pay and I am financially responsible for CVHD'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 CVHD of all benefits payable for the client's care.
- I understand the CVHD participated in the NDHIN. I understand that participation is voluntary and if I choose to opt out I must complete the NDHIN Opt Out/Revoke Opt Out form

Signature- Person to receive vaccine or person authorized to sign on the client's behalf:	Date:
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✓	Vaccine(s) To Be Given	Route <sup>1</sup>	VIS Date	MGF <sup>2</sup> (Circle)	Lot Number	S/P <sup>3</sup>	Admin Site <sup>4</sup>	Vaccine Administrator. <sup>5</sup>
	Chickenpox (varicella)	SQ	02/12/18	M				
	DTaP	IM	5/17/07	SP GSK				
	Hep A (HAV 2 doses) 12 mos-18 yrs	IM	07/20/16	M GSK				
	Hep A (HAV adult) 19 yrs & over	IM	07/20/16	GSK				
	Hep B (Hep B preservative free) 0-18	IM	07/20/16	M GSK				
	Hep B (HBV adult)	IM	07/20/16	GSK				
	HepA/HepB (HAV/HBV) Twinrix- Adult Only	IM	See HAV/HBV	GSK				
	Hib	IM	04/02/15	SP M				
	HPV9 Gardasil	IM	12/02/16	M				
	Influenza	IM	08/07/15	SP				
	IPV	IM/SQ	07/20/16	SP				
	Kinrix(Dtap/IPV) (5 <sup>th</sup> Dtap and 4 <sup>th</sup> IPV only)	IM	See Dtap/IPV	SP				
	MMR	SQ	02/12/18	M				
	MMRV	SQ	02/12/18	M				
	MCV4 (Meningococcal)	IM	03/31/16	SP				
	Pentacel(Dtap/IPV/Hib)	IM	See Dtap/lpv/H ib	SP				
	Pediarix(Dtap/IPV/Hep B)	IM	See Dtap/IPV/ Hep B	GSK				
	PCV13 Pneumococcal (conjugate) Prenar 13	IM	11/05/15	P				
	PPV23 Pneumococcal (polysaccharide) Pneumovax	IM	04/24/15	M				
	Rotavirus	PO	02/23/18	M				
	Td 7 yrs & over	IM	04/11/17	SP				
	Tdap	IM	02/24/15	GSK				
	Zoster (Shingles) Zostavax	SQ	02/12/18	M				
	Zoster(Shingles) Shingrix	IM	02/12/18	GSK				
<b>Signature and Title of Person Administering Vaccine:</b>						<b>Date Administered:</b>		

- Route:** IM = Intramuscular, SQ = Subcutaneous, IN = Intranasal, PO = Oral
- Manufacturer:** SP = sanofi pasteur (aventis), GSK = GlaxoSmithKline, M = Merck & Co., P = Pfizer
- Indicate if state-supplied or privately purchased:** S = State-supplied, P = Privately purchased
- Site Vaccine Given:** LA = Left Arm, RA = Right Arm, LUT = Left Upper Thigh, LLT= Left Lower Thigh, RUT = Right Upper Thigh, RLTL= Right Lower Thigh
- Signature or initials of person administering vaccine:** Can be used if more than one person is administering vaccines