Public Health
Prevent. Promote. Protect.

CENTRAL VALLEY HEALTH DISTRICT
ADULT INFLUENZA 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 Telephone Number:

Address (Street or P.O. Box)	City:	County:	State:	Zip Code:

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White/Caucasian ☐ Other/Unknown

Hispanic origin: ◯ Yes ◯ No

Sex: ◯ Male ◯ Female

Do you use tobacco products? ◯ Yes ◯ No

Are you exposed to second hand smoke? ◯ Yes ◯ No

Name of Primary Insurance Company: ◯BCBS ◯MCB ◯Medicaid ◯Sanford ◯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 ◯Sanford ◯Other _____	Policy or ID Number:	Group # (if applies):

Name of Policy Holder:	DOB of Policy Holder:	Address of Policy Holder:

THE FOLLOWING SCREENING QUESTIONS ARE TO DETERMINE WHICH INFLUENZA VACCINE YOU QUALIFY FOR.

1. Have you had a serious reaction to latex, food, medications or any vaccines? ◯ Yes ◯ No
2. Do you have history of Guillain-Barre (French Polio)? ◯ Yes ◯ No
3. Have you had a previous reaction to a flu shot? ◯ Yes ◯ No
4. Are you pregnant? ◯ Yes ◯ No
5. Do you have a chronic disease? ◯ Yes ◯ No
6. Are you sick today? ◯ Yes ◯ No

MY SIGNATURE BELOW INDICATES AUTHORIZATION, ACKNOWLEDGMENT, AND ASSIGNMENT OF INSURANCE BENEFITS:

- Information collected on this form will be used to document authorization for receipt/declination of vaccine(s). Information may be shared through the North Dakota Immunization Information System (NDIIS) with other entities. ND Century Code 23-01-05.3.
- I authorize the release of any medical or other information necessary to process this claim.
- I acknowledge that Central Valley Health District (CVHD) has provided me with their Notice of Privacy Practices. I understand I may request a copy of the Notice.
- 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 assign and authorize any third party payer/insurer to make direct payment to CVHD of all benefits payable for the client's care.
- I have read, or have had explained, the Vaccine Information Statement(s) about the vaccine(s) recommended 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) discussed and ask that those vaccine(s) be given to me or the person for whom I am authorized to make this request.
- I understand the CVHD participates in the North Dakota Health Information Network (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:

CLINIC USE ONLY

Vaccine to be Given	Route	VIS Date	Write in info or place sticker here	Admin Site	Vaccine Administrator
Inactivated Influenza Injection	**IM**	**2019/08/15**			

Signature and title of person administering the vaccine:	Date vaccine was administered:

Revised: 2019/09/20

Clear Form Print Form