CENTRAL VALLEY HEALTH DISTRICT
CHILD VACCINE ADMINSTRATION 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 Legal Name (Last, First, Middle Initial):	Date of Birth:	Age:	Home Telephone Number:	
Address (Street or P.O. Box):	City:		State:	Zip Code:
Client's Mother's Maiden Name:				

Please list Policy and Group Numbers for all insurances you may have:

Medicare Part B Policy #:	Group # if listed:	Policy Holder Name and Date of birth:
Blue Cross Policy #:	Group # if listed:	Policy Holder Name and Date of birth:
ND Medical Assistance #:	Group # if listed:	Policy Holder Name and Date of birth:
Sanford Policy #:	Group # if listed:	Policy Holder Name and Date of birth:
Other Insurance-Name of Company and Policy #:	Group # if listed:	Policy Holder Name and Date of birth:

Race: White African American Amer. Indian Asian Other	**Hispanic Origin:** Yes No	**Male** **Female**
Is the child using tobacco products? Yes No	**Is the child exposed to second hand smoke?** Yes No	

QUESTIONS 1-4 ARE TO DETERMINE WHETHER YOUR CHILD QUALIFIES FOR A FEDERALLY FUNDED IMMUNIZATION PROGRAM TITLED VACCINE FOR CHILDREN (VFC).

Yes No **1.** Is your child enrolled in Medicaid?
Yes No **2.** Does your child have more than one private health insurance policy?
Yes No Unknown **3.** Does your child's private health insurance cover vaccinations at Central Valley Health District?
Yes No **4.** Is your child Native American or Alaskan Native?

THE FOLLOWING SCREENING QUESTIONS ARE TO DETERMINE IF YOUR CHILD IS WELL ENOUGH TO RECEIVE THE FLU SHOT TODAY. DOES YOUR CHILD-

Yes No **5.** have any problems after receiving previous vaccines?
Yes No **6.** have any allergies to latex, food, medicine, or any vaccine?
Yes No **7.** have a brain problem; ever had a seizure or Guillain-Barre´ syndrome?
Yes No **8.** have a serious long-term health problem such as heart, lung, liver, or kidney disease, diabetes, etc.?
Yes No **9.** have any problems with his/her immune system, such as cancer, leukemia, or HIV/AIDS?
Yes No **10.** taken cortisone, prednisone, other steroids, anti-cancer drugs, or x-ray treatments in the past 3 months?
Yes No **11.** Is the child sick today?
Yes No **12.** Is the child pregnant or think she may be pregnant?
Yes No **13.** Received a previous does of seasonal flu vaccine? If so: 1 Dose 2 or more doses

If being done at the school, do you plan to be present when your child is vaccinated? 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 understand the CVHD participates 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.
- I authorize the release of any medical or other information necessary to process this claim.
- I acknowledge that 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.

Signature of client or person authorized to sign on the client's behalf:	Date:	School (if applicable):
X		

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	08/15/19			
Signature and Title of Person Administering Vaccine:				**Date Vaccine was Administered:**	

Revised 09/19