CENTRAL VALLEY HEALTH DISTRICT
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 Name (Last, First, Middle Initial):	**DOB:**	**Age:**	**Birth State:**	**Primary Phone Number:**	
Address (Street or P.O. Box):	**City:**		**County:**	**State:**	**Zip Code:**
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				

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 person receiving the shot is under the age of 18, please complete the following:

Parent or Legal Guardian:	**Relationship to Client:**	**Client's Mother's Maiden Name:**

THESE QUESTIONS ARE TO BE ANSWERED FOR THOSE 18 and UNDER ONLY 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).*

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. received any vaccines in the past four weeks?
Yes No 12. Is the person who is receiving the vaccine pregnant?
Yes No 13. Is the person receiving the vaccine sick today?
Yes No 14. Have read the Vaccine Information Statement about the vaccine you or your child will be receiving?
Yes No 15. If you are receiving COVID vaccine: Have you ever tested positive for COVID and received monoclonal antibodies or convalescent plasma in the last 90 days?

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:**

✓	Vaccine(s) To Be Given	Route [1]	VIS Date	MGF[2] (Circle)	Lot Number	S/P[3]	Admin Site[4]	Vaccine Administrator.[5]
	Chickenpox (varicella)	SQ/IM	01/31/25	M				
	COVID	IM	See latest version	P MO				
	DTaP	IM	08/06/21	GSK				
	Hep A (HAV Pediatric or Adolescent) 12 mos-18 yrs Pediatric	IM	01/31/25	GSK				
	Hep A (HAV adult) 19 yrs & over	IM	01/31/25	GSK				
	Hep B (HBV Pediatric or Adolescent) 0-18	IM	05/12/23	GSK				
	Hep B (HBV adult)	IM	05/12/23	GSK				
	HepA/HepB (HAV/HBV) Twinrix- Adult Only	IM	See HAV/HBV	GSK				
	Hib Pedvax	IM	08/06/21	M				
	HPV9 (Gardasil)	IM	08/06/21	M				
	Influenza	IM	01/31/25	SP GSK				
	IPV	IM/SQ	01/31/25	SP				
	Kinrix(Dtap/IPV) (5th Dtap and 4th IPV only)	IM	See Dtap/IPV	GSK				
	MenQuadfi (Meningococcal)	IM	01/31/25	SP				
	Mening B (Trumenba)	IM	01/31/25	P				
	MMR	SQ/IM	01/31/25	M				
	MMRV (Proquad)	SQ IM	01/31/25	M				
	MONKEYPOX-Jynneos	ID	11/14/22	Jynneos				
	PCV20	IM	05/12/23	P				
	Pentacel (Dtap/IPV/Hib)	IM	See Dtap/IPV/ Hib	M				
	PPV23 Pneumococcal (polysaccharide) Pneumovax	IM	10/30/19	M				
	Rotavirus 3 dose Rotateq	PO	10/15/21	M				
	RSV-Abrysvo-age 60+ only	IM	10/19/23	P				
	Tdap- Boostrix	IM	01/31/25	GSK				
	Zoster(Shingles) Shingrix	IM	02/04/22	GSK				
Signature and Title of Person Administering Vaccine:						**Date Administered:**		

	All vaccines due today were offered.

Any Vaccines declined today? Yes No _____

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

S: immunizations/vaccine administration record
Revised: 03/10/25