Public Health
Prevent. Promote. Protect.
Central Valley Health District

6100 CENTRAL VALLEY HEALTH DISTRICT
ADULT 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):	**Date of Birth:**	**Age:**	**Primary Phone Number:**	
Address (Street or P.O. Box):	**City:**		**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 ☐			

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:

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

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

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 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 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: X	**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	01/31/25			
Signature and Title of Person Administering Vaccine:			**Date Vaccine was Administered:**		