

**Vaccines for Children (VFC) Eligibility – Under 18:**

- American Indian/Alaskan Native     No Insurance  
 Medicaid-Eligible     Underinsured

**VACCINE ADMINISTRATION RECORD (VAR)**

<b>CLIENT INFORMATION</b>	Full Name: (Last, First, Middle)			Gender: <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	DOB:	Age:
	Address:			Hispanic or Latino: <input type="checkbox"/> YES <input type="checkbox"/> NO	Race: (check all that apply)	
	City:	State:	Zip:	Birth State or Country <i>(if not U.S.):</i>	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown	
	Telephone Number:		Email Address:			
	<b>IF CLIENT IS UNDER THE AGE OF 18:</b>					
Parent or Legal Guardian Name:			Relationship to Client:		Client's Mother's Maiden Name:	

<b>INSURANCE</b>	Primary Insurance Company: _____		ND Medicaid #: <input type="checkbox"/> N/A	Medicare #: <input type="checkbox"/> N/A
	Member ID #: _____			
	Group #:	Policyholder Name:	DOB: / /	
	Secondary Insurance Company <i>(includes Medicare Advantage)</i> : _____			
Member ID #:		Policyholder Name:	DOB: / /	

**VACCINATION ELIGIBILITY** **YES**   **NO**

1.	Do you feel sick today? <small>[All]</small>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you have allergies to medications, food, a vaccine component, or latex? <small>[All]</small>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy? <small>[All]</small>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease, asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy? <small>[MMR, VAR]</small>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do you have any conditions that may weaken the immune system (e.g. cancer, leukemia, HIV/AIDS)? <small>[MMR, VAR]</small>	<input type="checkbox"/>	<input type="checkbox"/>
6.	In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? <small>[MMR, VAR]</small>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you had a seizure, a brain disorder, or other nervous system problems? <small>[FLU, Td/Tdap]</small>	<input type="checkbox"/>	<input type="checkbox"/>
8.	In the past year, have you received immune globulin, blood products, or an antiviral drug? <small>[MMR, VAR]</small>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Have you received any vaccinations in the past 4 weeks? <small>[MMR, VAR]</small>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<b>For females:</b> Are you pregnant or chance of becoming pregnant in the next month? <small>[HPV, HepB, IPV, MMR, VAR]</small>	<input type="checkbox"/>	<input type="checkbox"/>
11.	<b>For infants:</b> Have you been told you have intussusception? <small>[MMR, VAR]</small>	<input type="checkbox"/>	<input type="checkbox"/>

**COVID-19 ONLY** **YES**   **NO**

12.	In the past 90 days, have you tested positive for COVID-19 or been treated with antibody treatment specifically for COVID-19 (monoclonal antibodies or convalescent plasma)?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Have you ever been diagnosed with a heart condition (myocarditis/pericarditis) or Multisystem Inflammatory Syndrome (MIS-A/MIS-C) after an infection with the virus that causes COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>

I acknowledge that Central Valley Health District (CVHD) has provided its Notice of Privacy Practices and that I may request a copy at any time. I authorize CVHD to use and disclose medical and billing information as necessary for treatment, payment, and health care operations, including insurance or third-party billing. I understand that I am financially responsible for charges not covered by a third-party payer and authorize direct payment of benefits to CVHD. I understand that CVHD participates in the North Dakota Health Information Network (NDHIN) and that participation is voluntary; I may opt out by completing the appropriate form. I acknowledge I was provided a copy of the applicable [CDC Vaccine Information Statement\(s\) \(VIS\)](#) prior to vaccination, have had the opportunity to ask questions, and understand the benefits and risks of the vaccine(s). I consent to administration of the vaccine(s) listed for myself or for the individual for whom I am legally authorized to consent and understand that vaccination information will be reported to the North Dakota Immunization Information System (NDIIS) in accordance with North Dakota Century Code 23-01-05.3.

<b>Signature:</b> <i>(Client or Authorized Person on Client's Behalf)</i>	<b>Date:</b>
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Client Name:	Age:	<input type="checkbox"/> PRIVATE <input type="checkbox"/> STATE
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**NURSE USE ONLY:**

VACCINE(S) TO BE GIVEN	AGES	MFR <sup>1</sup>	VIS DATE <sup>4</sup>	STATE <sup>5</sup> (S/P)	LOT NUMBER & EXP DATE	ROUTE <sup>2</sup>	SITE <sup>3</sup>	INITIALS <sup>6</sup>
<input type="checkbox"/> <b>COVID-19</b> SARS-CoV-2	12 YRS +	PFZ	01/31/2025			IM		
<input type="checkbox"/> <b>DTaP</b> Diphtheria-Tetanus-Pertussis	UNDER 7 YRS	GSK	08/06/2021			IM		
<input type="checkbox"/> <b>DTaP/Hib/IPV</b> PENTACEL	6 WKS – 4 YRS	MSD	08/06/2021 08/06/2021 01/31/2025			IM		
<input type="checkbox"/> <b>DTaP/IPV</b> KINRIX (5 <sup>th</sup> DtaP / 4 <sup>th</sup> IPV ONLY)	4 – 6 YRS	GSK	08/06/2021 01/31/2025			IM		
<input type="checkbox"/> <b>HAV</b> Hepatitis A PEDIATRIC ADULT	12 MO – 18 YRS 19 YRS +	GSK	01/31/2025			IM		
<input type="checkbox"/> <b>HAV/HBV</b> Hepatitis A-Hepatitis B TWINRIX	18 YRS +	GSK	01/31/2025 01/31/2025			IM		
<input type="checkbox"/> <b>HBV</b> Hepatitis B PEDIATRIC ADULT	BIRTH – 19 YRS 20 YRS+	GSK	01/31/2025			IM		
<input type="checkbox"/> <b>Hib</b> Haemophilus influenzae type b PEDVAX	UNDER 5 YRS	MSD	08/06/2021			IM		
<input type="checkbox"/> <b>HPV9</b> Human Papillomavirus GARDASIL	9 YRS – 45 YRS	MSD	08/06/2021			IM		
<input type="checkbox"/> <b>FLU</b> Influenza IIV3 P/F IIV3 P/F (HIGH-DOSE)	6 MO + 65 YRS +	SP GSK	01/31/2025			IM		
<input type="checkbox"/> <b>IPV</b> Poliovirus	6 WKS +	SP	01/31/2025			SQ IM		
<input type="checkbox"/> <b>MCV4</b> Meningococcal Conjugate	11 YRS – 55 YRS	SP	01/31/2025			IM		
<input type="checkbox"/> <b>Men B</b> Meningococcal B TRUMBENBA	16 YRS – 23 YRS	PFZ	01/31/2025			IM		
<input type="checkbox"/> <b>MMR</b> Measles-Mumps-Rubella	12 MO +	MSD	01/31/2025			SQ IM		
<input type="checkbox"/> <b>MMRV</b> MMR-Varicella PROQUAD	4 YRS – 12 YRS	MSD	01/31/2025			SQ IM		
<input type="checkbox"/> <b>PCV20</b> Pneumococcal Pneumonia PREVNAR	2 MOS +	PFZ	05/12/2023			IM		
<input type="checkbox"/> <b>ROTAVIRUS</b> ROTATEQ	UNDER 8 MO	MSD	10/15/2021			PO		
<input type="checkbox"/> <b>RSV</b> ABRYSVO	60 YRS +	PFZ	01/31/2025			IM		
<input type="checkbox"/> <b>Tdap</b> Tetanus-Diphtheria-Pertussis BOOSTRIX	7 YRS +	GSK	01/31/2025			IM		
<input type="checkbox"/> <b>VAR</b> Chickenpox	12 MO +	MSD	01/31/2025			IM		
<input type="checkbox"/> <b>ZOSTER</b> Shingles SHINGRIX	50 YRS +	GSK	02/04/2022			IM		

Vaccine Administrator Signature:	Date of Vaccination(s):
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All vaccines due today were administered?  YES  NO

If no, list declined vaccine(s): \_\_\_\_\_

1. MANUFACTURER	2. ROUTE	3. ADMIN SITE
GSK GlaxoSmithKline	ID Intradermal	LA Left Arm
MSD Merck & Co.	IM Intramuscular	RA Right Arm
PFZ Pfizer	IN Intranasal	LT Left Thigh
SP Sanofi Pasteur	PO Oral	RT Right Thigh
	SQ Subcutaneous	

PAYMENT	
Amount: \$	<input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Card <input type="checkbox"/> Bill

OFFICE USE ONLY:			
<input type="checkbox"/> INS CARD SCANNED	<input type="checkbox"/> NDIIS	<input type="checkbox"/> AHLERS	<input type="checkbox"/> BILLED

4. **VIS DATE:** Date of the vaccine information statement (VIS) or emergency authorization use (EUA) fact sheet, if applicable.  
 5. **STATE VACCINE:** The presence of a checkmark indicates if the vaccine was state supplied through the Vaccines for Children (VFC) or Vaccines for Adults (VFA) program. If the box remained unchecked, the vaccine was privately purchased.  
 6. **VACCINE ADMINISTRATOR:** Signature or initials of person administering the vaccine.