Central Valley Health District
Nursing Department
Seasonal Vaccine Consent Form

ADULT
VACCINE ADMINISTRATION RECORD (VAR)

CLIENT INFORMATION

Full Name: (Last, First, Middle)	Gender: ☐ FEMALE ☐ MALE	DOB:	Age:
Address:	Hispanic or Latino: ☐ YES ☐ NO	Race: (check all that apply) ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Unknown	
City: / State: / Zip:	Birth State or Country (if not U.S.):		
Primary Telephone Number:	Email Address:		

INSURANCE

Primary Insurance Company *(includes Medicare Advantage)*: _____ Medicare #: ☐ N/A

Member ID #:_____ Group #: _____

Policyholder Name: DOB: / /

ND Medicaid #: ☐ N/A

Secondary Insurance Company: _____

Member ID #: Policyholder Name: DOB: / /

VACCINATION ELIGIBILITY	YES	NO
1. Do you feel sick today?	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐
3. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?	☐	☐
4. Have you had a seizure, a brain disorder, or other nervous system problem (i.e. Guillain-Barré)?	☐	☐

COVID-19 ONLY	N/A	YES	NO
5. 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)?	☐	☐	☐
6. 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?	☐	☐	☐

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.

Signature: (Client or Authorized Person on Client's Behalf)	Date:

NURSE USE ONLY:

VACCINE(S) TO BE GIVEN	AGES	VIS DATE	STATE (S/P)	LOT NUMBER & EXP DATE	ROUTE	SITE	INITIALS
☐ **COVID-19** *SARS-CoV-2* PFIZER	12 YRS +	01/31/2025			IM		
FLU *Influenza* ☐ IIV3 P/F ☐ IIV3 P/F (HIGH-DOSE)	6 MO + 65 YRS +	01/31/2025			IM		

Vaccine Administrator Signature:	Date of Vaccination(s):

CENTRAL VALLEY HEALTH DISTRICT
122 2nd St NW, Jamestown, ND 58401
P: 701-252-8130 F: 701-252-8137

OFFICE USE ONLY:						
☐ INS CARD SCANNED	☐ NDIIS	☐ AHLERS	☐ BILLED	Amount: $	☐ Cash ☐ Card	☐ Check ☐ Bill