LAMOURE COUNTY HEALTH DEPARTMENT VACCINE ADMINISTRATION RECORD

100 1ST Ave SW – First State Mall, LaMoure ND 58458, Phone: (701) 883-5356 Fax: (701) 883-5015

PLEASE PRINT INFORMATION ABOUT PERSON TO RECEIVE VACCINE.

Client's Name (Last, First, Middle Initial):	Date of Birth:	Age:	Male	Female

Name of Parent or Guardian Responsible for Client:	Relationship to Client:

Address (Street or P.O. Box):	City:	County:	State:	Zip Code:

Home Telephone Number:	Cell Number:	Race:
		○ White ○ Black/African American ○ Asian ○ American Indian/Alaskan ○ Pacific ○s./Hawaiian ○
Name of Insurance Company:	Insurance Policy Number:	
Policy Holder Name	Policy Holder Date of Birth	Does your child's health insurance cover vaccines? Yes No

VACCINATION SCREENING QUESTIONS REGARDING THE VACCINE RECIPIENT

Yes	No	Is the client sick today?
Yes	No	Does the client have an allergy to medications, food, a vaccine component, or latex?
Yes	No	Has the client had a serious reaction (anaphylaxis) to any vaccine in the past?
Yes	No	Does the client have any chronic health conditions? _____
Yes	No	If the client is a baby, have you ever been told he/she has had intussusception?
Yes	No	If the client to be vaccinated is 2-4 years of age, has a health care provider told you that your child has wheezing or asthma in the past 12 months?
Yes	No	Has the client, sibling, or parent had seizure, brain, or other nervous system problems?
Yes	No	Client has problems with his/her immune system – such as cancer, leukemia, HIV/AIDS, organ transplant?
Yes	No	In the last three months, has the client taken medications that affect their immune system such as prednisone, other steroids or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or radiation treatments?
Yes	No	In the past year, has the client received a transfusion of blood or blood products, or been given immune (gamma) globulin or antiviral drug? Date?_____
Yes	No	Is the client pregnant or is there the chance she could become pregnant during the next month?
Yes	No	Has the client received LIVE vaccinations in the last four week?
Yes	No	Has the client to be vaccinated ever received a dose of COVID-19 vaccine? Type_____ # of Doses _____
Yes	No	Has the client had history of: myocarditis or pericarditis_____, MIS-C_____,Thrombocytopenia_____, Guillsin-Barre_____, COVID in last 3 months_____
Yes	No	Have you read or received a vaccine information statement pertaining to the vaccines you/your child with receive?

LaMoure Co Health Dept may contact me via text/ email: YES/NO Please contact me_____

School Shot Clinics ONLY

The vaccines that are due for your child are highlighted. Check the vaccines you wish your child to receive.

Required for School

☐ **Polio**

☐ **DTaP**

☐ **Kinrix(dtap/ipv)**

Hepatitis B
☐ 1st Dose
☐ 2nd Dose
☐ 3rd Dose

Varicella Chicken Pox
☐ 1st Dose
☐ 2nd Dose

MMR
☐ 1st Dose
☐ 2nd Dose

☐ **MMRV**

☐ **Tdap**

☐ **Meningococcal**
☐ 1st Dose
☐ 2nd Dose

Recommended

Hepatitis A
☐ 1st Dose
☐ 2nd Dose

Men B
☐ 1st Dose
☐ 2nd Dose

HPV
☐ 1st Dose
☐ 2nd Dose
☐ 3rd Dose

☐ **Flu**

☐ **COVID**

MY SIGNATURE BELOW INDICATES:

1. 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.)
2. 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.
3. I acknowledge LaMoure County Health Dept. has provided me with their Notice of Privacy Practices. I understand I may request a copy of the Notice.
4. I authorize the release of any medical or other information necessary to process this claim.
5. 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 LaMoure County Health Dept. established charges provided to the Client not covered by a third-party payer.
6. I assign and authorize any third-party payer/insurer to make direct payment to LaMoure County Health Dept. of all benefits payable for the Client's care.

Signature- Person to receive vaccine or person authorized to sign on the client's behalf:	Date:

FOR OFFICE USE ONLY

LAMOURE COUNTY HEALTH DEPT. VACCINE ADMINISTRATION RECORD (VAR)

✓	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	08/06/21	M				
	DTaP	IM	08/06/21	SP GSK				
	DTAP/HBV/IPV (Pediarix)	IM	08/06/21	GSK				
	Hep A (HAV 2 doses) pediatric- 12 mos-18 yrs	IM	10/15/21	GSK				
	Hep A (HAV adult) 19 yrs & over	IM	10/15/21	GSK				
	Hep B (Hep B preservative free) pediatric- 0-18	IM	10/15/21	GSK				
	Hep B (HBV adult)	IM	10/15/21	GSK				
	Hib	IM	08/06/21	GSK				
	Rotovirus	PO	10/15/21	GSK				
	Men B **BEXERO OR TRUMEMBA???**	IM	08/06/21	P				
	HPV9 (Gardasil)	IM	08/06/21	M				
	Influenza Inactivated (TIV)	IM	08/06/21	SP				
	Influenza Live Intranasal (LAIV)	nasal	08/06/21	Med Imm				
	Influenza High Dose	IM	08/06/21	SP				
	Kinrix (IPV #4/DTAP #5 for 4-6yr olds)	IM	08/06/21	GSK				
	MMR	SQ	08/06/21	M				
	MMRV ProQuad	SQ	08/06/21	M				
	MCV4 (Meningococcal) 2-55 yrs	IM	08/06/21	GSK				
	PCV13 Pneumococcal (conjugate) Prevnar	IM	08/06/21	Pfizer				
	PPSV23 Pneumococcal (polysaccharide) Pneumovax 65 yrs & over	SQ/IM	08/06/21	M				
	PCV20 (conjugate) Prevnar 20 Pneumococcal	IM		Pfizer				
	IPV (polio)	IM/SQ	08/06/21	SP				
	TDaP (Adacel) 7-64 yrs	IM	08/06/21	SP				
	Shingirix (RZV) (Shingles) 50 yrs & older	IM	02/04/22	GSK				
	COVID Moderna	IM		M				
	RSV	IM						
Signature and Title of Professionals Administering Vaccine:						**Date Administered:**		

1. **Route:** IM = Intramuscular, SQ = Subcutaneous, IN = Intranasal, PO = Oral
2. **Manufacturer:** SP = sanofi pasteur (aventis),, GSK = GlaxoSmithKline, M = Merck & Co., W = Wyeth
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