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 ○		
ND Medicaid Number:	**Medicare Part B Number:**			
Name of Insurance Company:		**Insurance Policy Number:**		
Address of Insurance Company:		**Name and Date of Birth of Policy Holder:**		
Date of Service:		**Immunization Provider Number 53**		

VACCINATION SCREENING QUESTIONS REGARDING THE VACCINE RECIPIENT

Yes	**No**	**Has the recipient had a serious reaction after receiving previous vaccines?**
Yes	No	Does the recipient have any allergies to food, medicine, or any vaccine? If yes, please list:_____
Yes	**No**	**Is the recipient sick today?**
Yes	No	Does the recipient have any problems with his/her immune system, such as cancer, leukemia, or HIV/AIDS?
Yes	**No**	**Has the recipient taken cortisone, prednisone, other steroids, or anti-cancer drugs, or radiation treatments in the past 3 months?**
Yes	No	Has the recipient received any vaccines in the past four weeks?
Yes	**No**	**Is the person who is receiving the vaccine pregnant or possibly become pregnant in the next 4 weeks?**
Yes	No	Has the recipient had a seizure or other brain/nervous system problem?
Yes	**No**	**Has the recipient received a transfusion of blood/blood products, or been given immune globulin or an antiviral drug in the last year?**
Yes	No	Have you read the important Information Statement about the vaccine you or your child will be receiving?

THE FOLLOWING QUESTIONS ARE TO BE ANSWERED BY THE PARENT/GUARDIAN OF PERSONS 18 YEARS OF AGE AND YOUNGER

(Used to determine if children 18 years of age or younger qualify for a federally funded immunization program titled Vaccine for Children.)

Yes	**No**	**Is your child enrolled in Medicaid?**
Yes	No	Does your child have health insurance?
Yes	**No**	**Does your child's health insurance cover vaccinations?**
Yes	No	Is your child Native American or Alaskan Native?

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

Required for School

☐ **DTaP**

MMR
☐ 1st Dose
☐ 2nd Dose

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

Varicella (Chicken Pox)
☐ 1st Dose
☐ 2nd Dose

☐ **Tdap**

☐ **Polio**

☐ **Meningococcal**

Recommended

Hepatitis A
☐ 1st Dose
☐ 2nd Dose

HPV
☐ 1st Dose
☐ 2nd Dose
☐ 3rd Dose

If your child has had Varicella (chicken pox) disease, please enter the date of illness on this line _____

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	3/13/08	M				
	DTaP	IM	5/17/07	SP GSK				
	DTAP/HBV/IPV (Pediarix)	IM	11/5/15	GSK				
	Hep A (HAV 2 doses) pediatric- 12 mos-18 yrs	IM	7/20/2016	GSK				
	Hep A (HAV adult) 19 yrs & over	IM	7/20/2016	GSK				
	Hep B (Hep B preservative free) pediatric- 0-18	IM	7/20/2016	GSK				
	Hep B (HBV adult)	IM	7/20/2016	GSK				
	Hib ActHib / PedvaxHIB	IM	4/2/15	SP M				
	DTAP/IPV/HIB (Pentacel)	IM	see individual	SP				
	HPV9 (Gardasil)	IM	3/31/16	M				
	Influenza Inactivated (TIV)	IM	8/7/15	SP				
	Influenza Live Intranasal (LAIV)	nasal	8/7/15	Med Imm				
	IPV (polio)	IM/SQ	7/20/16	SP				
	Kinrix (IPV #4/DTAP #5 for 4-6yr olds)	IM	11/5/2015	GSK				
	MMR	SQ	4/20/12	M				
	MMRV ProQuad	SQ	5/21/10	M				
	MCV4 (Meningococcal) Menactra 2-55 yrs	IM	3/31/16	SP				
	PCV13 Pneumococcal (conjugate) Prevnar	IM	11/5/16	W				
	PPSV23 Pneumococcal (polysaccharide) Pneumovax 65 yrs & over	SQ/IM	4/24/15	M				
	Rotateq (rotovirus)	PO	4/15/15	M				
	Td 7 yrs & over	IM	2/24/15	SP				
	TDaP (Adacel) 7-64 yrs	IM	2/24/15	SP				
	Zostavax (Shingles) 60 yrs & over	SQ	10/06/09	M				
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

Tobacco Use (circle those that apply): Never Current User Former User Second Hand Smoke (Y) (N) Chews

Parent Chews Precontemplative Contemplative Preparing Action Maintenance

Fax Referral to NDQuits ND Quits/net Info Given Secondhand Smoke Info Given

ND Quits/net Info Denied