CENTRAL VALLEY HEALTH DISTRICT
VACCINE ADMINSTRATION RECORD (VAR) FOR SERIES

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):	**DOB:**	**Age:**	**Birth State:**	**Primary Phone Number:**
Address (Street or P.O. Box):	**City:**		**County:**	**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

Name of Primary Insurance Company: **Medicare BCBS Sanford Medicaid Other:** ____________________	**Policy or ID Number:**	**Group # (if applies):**
Name of Policy Holder: / **DOB of Policy Holder:**	**Address of Policy Holder:**	
Name of Secondary Insurance Company: **BCBS Sanford Medicaid Other:** ____________________________	**Policy or ID Number:**	**Group # (if applies):**

If client is under the age of 18, please complete the following:

Parent or Legal Guardian:	**Relationship to Client:**	**Client's Mother's Maiden Name:**

THESE QUESTIONS ARE TO BE ANSWERED BY THE PERSON RECEIVING THE VACCINE OR PARENT/GUARDIAN MAKING THE REQUEST.
Questions 1 – 4 are used to determine if children 18 years of age or younger qualify for a federally funded immunization program titled Vaccine for Children (VFC). ***Questions 5-14 pertain to the person receiving the vaccinations, question 15 addresses information regarding the vaccine.***

Yes No 1. Is your child enrolled in Medicaid?
Yes No 2. Does your child have health insurance?
Yes No 3. Does your child's health insurance cover vaccinations?
Yes No 4. Is your child Native American or Alaskan Native?

Yes No 5. Had any problems after receiving previous vaccines?
Yes No 6. Have any allergies to food, medicine, or any vaccine?
Yes No 7. Have a brain problem or ever had a seizure?
Yes No 8. Have any problems with his/her immune system, such as cancer, leukemia, or HIV/AIDS?
Yes No 9. Taken cortisone, prednisone, other steroids, anti-cancer drugs, or x-ray treatments in the past 3 months?
Yes No 10. Received any blood products or Immune Globulin in the past year?
Yes No 11. Had chickenpox? If yes, date of disease if known____________________
Yes No 12. Received any vaccines in the past four weeks?
Yes No 13. Is the person who is receiving the vaccine pregnant?
Yes No 14. Is the person receiving the vaccine sick today?
Yes No 15. Have you read the Vaccine Information Statement about the vaccine you or your child will be receiving?

MY SIGNATURE BELOW INDICATES:

- I have read, or have had explained, information about the vaccine(s) to be administered 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) 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.)
- 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.
- I acknowledge CVHD has provided me with their Notice of Privacy Practices. I understand I may request a copy of the Notice.
- I authorize the release of any medical or other information necessary to process this claim.
- 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 CVHD's established charges provided to the Client not covered by a third-party payer.
- 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 understand CVHD participated 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

Check all vaccines your child is to receive:

_____HPV9- Gardasil. Checking here gives permission to begin and/ or complete the series, as age appropriate.
_____Meningitis-Menactra- one dose required for 7th grade entry and booster dose required at age 16.
_____Tdap-one dose required for 7th grade entry
_____Other vaccines requested-Please circle if needed: Flu, Hepatitis A, Chickenpox Booster, Shingles

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

For Office Use only:--

✓	Vaccine(s) To Be Given	Route [1]	VIS Date	MGF[2] (Circle)	Lot Number	S/P[3]	Admin Site[4]	Vaccine Administrator.[5]
	HPV9 Gardasil	IM	12/02/16					
	MCV4 Menactra	IM	08/24/18	SP				
	Tdap	IM	02/24/15	GSK				
	Meningitis B	IM	08/09/16	W				

Signature and Title of Person Administering Vaccine:	Date Administered:

Parent notified of 2nd series on ___________; Changes in health status? Yes/No RN notifying parents: ________________________

✓	Vaccine(s) To Be Given	Route [1]	VIS Date	MGF[2] (Circle)	Lot Number	S/P[3]	Admin Site[4]	Vaccine Administrator.[5]
	HPV9 Gardasil	IM	12/02/16					
	MCV4 Menactra	IM	08/24/18	SP				
	Tdap	IM	02/24/15	GSK				
	Meningitis B	IM	08/09/16	W				

Signature and Title of Person Administering Vaccine:	Date Administered:

Parent notified of 3rd series on ________________; Change in health status? Yes/No RN notifying parents________________________

✓	Vaccine(s) To Be Given	Route [1]	VIS Date	MGF[2] (Circle)	Lot Number	S/P[3]	Admin Site[4]	Vaccine Administrator.[5]
	HPV9 Gardasil	IM	12/02/16					
	MCV4 Menactra	IM	08/24/18	SP				
	Tdap	IM	02/24/15	GSK				
	Meningitis B	IM	08/09/16	W				

Signature and Title of Person 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

S: immunizations/vaccine administration record series
08/15/2015; 12/14/2016; 02/08/2017; 08/28/18