PEMBINA COUNTY VACCINE ADMINISTRATION RECORD FOR IMMUNIZATIONS

Information collected on this form will be used to document authorization of receipt of vaccine(s) and may be shared through the North Dakota Immunization Information System (NDIIS) with other entities in accordance with North Dakota Century Code 23-01-05.3.

Name (Last, First, MI)		**Birthdate**	**Gender** M F Other	**Age**
Hispanic or Latino ☐ Yes ☐ No **Race** ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Asian	**Mother's Name** **Mother's Maiden Name**	**Contact Method** Home _____ Cell _____ Email _____		
Address	**City**	**County**	**State**	**Zip Code**
Insurance Company	**Policy Number/Medicaid ID Number**	**Fees Collected** ☐ Cash ☐ Check ☐ Credit Card		
Policy Holder's Name	**Policy Holder's Date of Birth**	**Policy Holder's Address if different than above**	**Policy Holder's Phone**	
Circle those that apply to your child **American Indian/Alaskan Native** **Medicaid Eligible** **No Insurance** **Underinsured** **Private Insurance**				

	Circle Response		
1. Is the child sick today?	Yes	No	Don't know
2. Does the child have allergies to any medications, food, or a vaccine component or latex?	Yes	No	Don't know
List all allergies:_____			
3. Has the child had a serious reaction to a vaccination in the past?	Yes	No	Don't know
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	Yes	No	Don't know
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	Yes	No	Don't know
6. If your child is a baby, have you ever been told he/she has had intussusception?	Yes	No	Don't know
7. Has child, a sibling, or parent had a seizure; has the child had brain or other nervous system problems?	Yes	No	Don't know
8. Does the child or family member have cancer, leukemia, HIV/AIDS, or other immune system problems?	Yes	No	Don't know
9. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's Disease, or psoriasis; or had radiation treatments?	Yes	No	Don't know
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	Yes	No	Don't know
11. Is the child pregnant or is there a chance she could become pregnant during the next month?	Yes	No	Don't know
12. Has the child received vaccinations in the past 4 weeks?	Yes	No	Don't know
13. Does the child currently use tobacco? ***[NURSE: If yes, ☐ Advised ☐ Referred]***	Yes	No	Don't know
14. Is the child exposed to second hand smoke?	Yes	No	Don't know
15. Do you consent to electronic communication including text or e-mail?	Yes	No	

[Updated from www.immunize.org/cat.d/p4060.pdf Item #P4060 (9/17)

By my signature below, I am acknowledging that the office of the Pembina County Public Health Department agrees to provide me with their Notice of Privacy Practices upon my request and permission to enter this information into the electronic health record.

A copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Statement(s) has been provided. I have read, or have had explained, the information about the disease(s) and the vaccine(s) listed. There was an opportunity to ask questions and all questions were answered satisfactorily. I understand the benefits and risks of the vaccine(s) cited, and ask that the vaccine(s) listed be given to the person named above (for whom I am authorized to make this request).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 Pembina County Public Health Department'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 Pembina County Public Health Department of all benefits payable for the Client's care.

Signature of person authorized to make the request to receive the vaccine(s) and completion of this questionnaire.

X _____ **Date** _____

Revised 5/31/19

FOR PCPH USE ONLY:

VACCINE ADMINISTRATION RECORD

Pembina County Public Health (Provider #29) 301 Dakota Street West #2 Cavalier, ND 58220 701-265-4248

✓	Vaccine(s) to be given	Route[1]	VIS Date[2]	Manufacturer [3]	Lot No.	S/P[4]	Site[5]	Admin.[6]
	DTaP	IM		GSK SP				
	DTaP-HepB-IPV (Pediarix®)	IM		GSK				
	DTaP-IPV/Hib (Pentacel®)	IM		SP				
	DTaP-IPV (Kinrix®)	IM		GSK				
	Hepatitis A	IM		GSK MSD				
	Hepatitis B	IM		GSK MSD				
	Hep A-Hep B (Twinrix®)	IM		GSK				
	Hib (*H. influenza* type B)	IM		GSK MSD SP				
	HPV	IM		GSK MSD				
	Influenza	ID/IM/IN		SP				
	IPV	IM/SQ		SP				
	MMR	SQ		MSD				
	MMRV	SQ		MSD				
	Meningococcal Conjugate	IM		NOV SP				
	Meningococcal B	IM		GSK PFZ				
	Pneumococcal Conjugate	IM		PFZ				
	Pneumococcal Polysaccharide	IM/SQ		MSD				
	Rotavirus	PO		GSK MSD				
	Td	IM		MBL SP				
	Tdap	IM		GSK SP				
	Shingles	SQ		MSD				
	Varicella	SQ		MSD				

Exemption or contraindiction[7]:	Date of exemption or contraindication:
Signature and title of person administering vaccine:	Date vaccine administered:

1. Route: ID = Intradermal, IM=Intramuscular, IN=Intranasal, PO=Oral, SQ=Subcutaneous
2. VIS Date: Document the publication date of the appropriate VIS. If VIS is given on a date other than the date of vaccination, also document the date VIS was given to patient or individual responsible for the patient.
3. Manufacturer: GSK=GlaxoSmithKline, MBL=Massachusetts Biological Laboratories, MSD=Merck & Co., NOV=Novartis, PFZ-Pfizer, SP=Sanofi Pasteur
4. Indicate if state-supplied or privately purchased: S=State-supplied, P=Privately purchased
5. Site Vaccine Given: LA=Left Arm, RA=Right Arm, LT = Left Thigh, RT=Right Thigh
6. Signature or initials of person administering vaccine: Can be used if more than one person is administering vaccines
7. Exemption or Contraindication: MED=Medical, REG=Religious, PHIL=Philosophical, MOR=Moral, HOD=History of Disease (Please indicate date of exemption, contraindication or disease)