VACCINE ADMINISTRATION RECORD

Foster County Public Health FLU SERIES

881 Main Street, Carrington, ND 58421 (701) 652-3087

Information collected on this form will be used to document authorization of receipt of vaccine(s). Information may be shared through the North Dakota

NDIIS Provider Number

46

Immunization Information System (NDIIS) with other entities in accordance with North Dakota Century Code 23-01-05.3. Print Patient's Name (Last, First, Middle Initial): Date of Birth: Gender: Age: ☐ Male ☐ Female Address (Street or PO Box): State: Zip Code: City: County: Home Phone # Cell# Work # Name of Responsible Financial Party: Address if different from Patient's address: □ Native American □ Alaskan Native □ No Insurance □ Underinsured (Vaccines not covered by health insurance) ☐ Insured (Vaccines covered by health insurance – Not VFC eligible) ☐ Medicaid – Enter Number_ **Birth State/Country** Race **Ethnicity** Screening Questions for person getting vaccinated □YES □NO □DON'T KNOW Are you sick today? Do you have allergies to medications, food, a vaccine component, or latex? □YES □NO □DON'T KNOW □YES □NO Have you ever had a serious reaction after receiving a vaccination? □DON'T KNOW Do you have a long-term health problem with heart disease, lung disease, (e.g., asthma), kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), \square YES \square NO □DON'T KNOW anemia or another blood disorder? Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? \square YES \square NO □DON'T KNOW Have you had a seizure, brain or other nervous system problems including Guillain-Barre \square YES \square NO □DON'T KNOW (paralyzing polio)? During the past year, have you received a transfusion of blood or blood products or been given \square YES \square NO □DON'T KNOW immune (gamma) globulin or an antiviral drug? For women: Are you pregnant or is there a chance you could become pregnant during the next \square YES □DON'T KNOW \square NO Have you received any vaccinations in the past 4 weeks? \square YES \square NO □DON'T KNOW Have you had shingles within the last year? \square YES \square NO □DON'T KNOW In the past 3 months, have you taken medication that affects your immune system such as prednisone, other steroids, or drugs for the treatment of cancer, rheumatoid arthritis, Crohn's □YES □NO □DON'T KNOW disease, psoriasis or had radiation treatment? Do you currently smoke, chew, vape or have exposure to secondhand smoke? □YES □NO □DON'T KNOW Are you a prior □smoker, □chewer, □electronic nicotine user/vape/JUUL? □YES □NO □DON'T KNOW Quit date: Quitline Referral Accepted Yes□ N/A□ Referral Refused □ (Please initial) ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS I authorize the release of any medical or other information necessary to process this claim. I consent to data entry into the ND state registry. A copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Statement(s) (VIS) has been provided. I have read, or have had explained, the information about the disease(s) and the vaccine(s) listed below. There was an opportunity to ask questions and all questions were answered satisfactorily. I believe that I understand the benefits and risks of the vaccine(s) cited and ask that the vaccine(s) listed below be given to me or to the person named above (for whom I am authorized to make this request). Patient refused VIS If I am the Client, or an individual legally obligated to pay for medical services provided to the Client or a Guarantor of payment, I agree to pay and I am financially responsible for the Local Public Health Unit'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 the Local Public Health Unit of all benefits payable for the Client's care. (minor not allowed to sign) Signature of patient or responsible person relationship to patient date

VACCINE ADMINISTRATION RECORD

		NDHS Provider Number 46
Patient Name	Date of Birth	Revised 10/14/2022
		Foster County Public Health

881 Main Street, Carrington, ND 58421 701) 652-3087

REV: 10/14/2022

Dat	te/Time Vaccine Admin	istered:				□Patient (did not wait 15 minutes
X	Vaccine(s) To Be Given	VIS Date	Manu- factur er	Lot Number	Route	Administration Site	Nurse Signature
	Medicare HD private 0.7ML	08/06/21	SFP		IM	R Upper Arm L Lower Thigh	
	Fluzone (MDV) Private 0.5ML	08/06/21	SFP		IM	R Upper Arm L Lower Thigh	
	Fluzone-PFS Private 0.5ML	08/06/21	SFP		IM	R Upper Arm L Lower Thigh	
	Flucelvax-PFS VFC 0.5ML	08/06/21	Seqirus		IM	R Upper Arm L Lower Thigh	
	Flucelvax-PFS 317 0.5ML ADULT 19 +	08/06/21	Seqirus		IM	R Upper Arm L Lower Thigh	
	Fluzone (MDV) VFC 0.5ML	08/06/21	SFP		IM	R Upper Arm L Lower Thigh	
	Medicare 65+ Fluzone MDV 0.5ML	08/06/21	SFP		IM	R Upper Arm L Lower Thigh	
Dat	 re/Time Vaccine Administe	ered:				□ Patient	t did not wait 15 minutes
K	Vaccine(s) To Be Given	VIS Date	Manu- factur er	Lot Number	Route	Administration Site	Nurse Signature
					IM	R Upper Arm L Lower Thigh	
	Fluzone (MDV) Private 0.5ML	08/06/21	SFP		IM	R Upper Arm L Lower Thigh	
	Fluzone-PFS Private 0.5ML	08/06/21	SFP		IM	R Upper Arm L Lower Thigh	
	Flucelvax-PFS VFC 0.5ML	08/06/21	Seqirus		IM	R Upper Arm L Lower Thigh	
	Fluzone (MDV) VFC 0.25ML 0.5ML	08/06/21	SFP		IM	R Upper Arm L Lower Thigh	

- 1. Route: IM = Intramuscular, SQ = Subcutaneous, IN = Intranasal, PO = Oral
 2. Manufacturer: SFP = Sanofi Pasteur, GSK = GlaxoSmithKline, MSD = Merck & Co., WAL = Wyeth, MB=Mass Biologics

- 2. Manufacture: SPF = Sanoti Pasteur, GSA = GlaxOsinhtikinie, MSD = Melck & Co., WAL = Wyeur, MB=Mass Biologics

 REV: 10/14/2022

 3. Site Vaccine Given: R = Right, L = Left

 4. Presentation: PPS=Prefilled Syringe, MDV=Multidose vial

 5. Origin: VFC=Vaccine for children, 317=Uninsured & Underinsured adults

 6. Exemption or Contraindication: MED = Medical, REL = Religious, PBE = Philosophical/ Moral, HD = History of Disease (See Refusal to Vaccinate Form)