CAVALIER COUNTY HEALTH DISTRICT SCHOOL VACCINE ADMINSTRATION RECORD

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Tax ID Number: 45-0427926 NPI Number: 1174566335

THESE QUESTIONS ARE TO BE ANSWERED BY THE PERSON RECEIVING THE VACCINE OR PARENT/GUARDIAN MAKING THE REQUEST.
Questions 1 – 3 are used to determine if children 18 years of age or younger qualify for a federally funded immunization program titled Vaccine for Children (VFC).

□ Yes □ No **1.** Is your child enrolled in Medicaid?
□ Yes □ No **2.** Does your child have private health insurance that covers vaccinations?
□ Yes □ No **3.** Is your child Native American or Alaskan Native?

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

Address (Street or P.O. Box):	**City:**	**State:**	**Zip Code:**	**Phone Number:**

Grade:	**Teacher:**	*** ND Medicaid Number:**	***Insurance Policy Number:**

Name of Policy Holder:	**Date of Birth:**	**Address if different from client's address:**	**Relationship to Client:**

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS
(Please read and sign below)

I acknowledge that I have been provided with Cavalier County Health District's Notice of Privacy Practices. I understand I may request an additional copy of the Notice at future contacts with Cavalier County Public Health.

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 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).

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 services provided to the Client or a Guarantor of payment, I agree to pay and I am financially responsible for Cavalier County Health District'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 Cavalier County Health District of all benefits payable for the Client's care.

Which vaccine(s) are you consenting for the client to receive?
□ Influenza
□ Moderna COVID-19
□ Pfizer COVID-19

Do you wish to be present for your child's vaccination(s)? □ Yes □ No

SCREENING QUESTIONS - DOES THE PERSON RECEIVING THE VACCINE:

□ Yes □ No **1.** Person receiving vaccine sick today?
□ Yes □ No **2.** If receiving COVID-19 vaccine, have you received a dose of COVID-19 vaccine?
□ Yes □ No **3.** Allergies to medications, injectables, food, a vaccine component or latex?
Please list any allergies: _____
□ Yes □ No **4.** Serious reaction after receiving a previous vaccine?
□ Yes □ No **5.** Have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? (Child on long-term aspirin therapy?)
□ Yes □ No **6.** Have cancer, leukemia, HIV/AIDS, or any other immune system problem?
□ Yes □ No **7.** In the past 3 months, has taken medications that affect the immune system, such as prednisone, other steroids, or anticancer drugs; drugs for treatment of rheumatoid arthritis, Crohn's disease, psoriasis or had radiation treatments?
□ Yes □ No **8.** Have had a seizure or brain or other nervous system problem?
□ Yes □ No **9.** During the past year has received a transfusion of blood or blood products or been given immune (gamma) globulin, or an antiviral drug?
□ Yes □ No **10.** Females - Pregnant or chance of becoming pregnant in the next month?
□ Yes □ No **11.** Have received any vaccinations in the past 4 weeks?

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 ND Century Code 23-01-05.3.

Signature of Person to receive vaccine or person authorized to sign on the client's behalf:	**Date:**
Printed Signature and Relationship to Client:	

Office Use Only

	Vaccine(s) To Be Given	Route	VIS Date	MGF (Circle)	Lot Number	S/P[1]	Admin Site[2]	Vaccine Administrator
	DTaP	IM	8/6/21	GSK				
	DTaP-IPV	IM	8/6/21 8/6/21	GSK				
	DTaP/HIB/IPV	IM	8/6/21 8/6/21 8/6/21	Sanofi				
	DTaP/IPV/Hib/HepB	IM	8/6/21 8/6/21 8/6/21 5/12/23	Sanofi				
	Hep A (2 doses) ped - 12 mos-18 yrs	IM	10/15/21	GSK				
	Hep A adult – 19yrs+	IM	10/15/21	GSK				
	Hep B (PF) ped - 0-19 yrs	IM	5/12/23	GSK				
	Hep B adult - 20 yrs & over	IM	5/12/23	GSK				
	Hib	IM	8/6/21	Sanofi				
	HPV-9	IM	8/6/21	Merck				
	IPV	IM/SQ	8/6/21	Sanofi				
	MMR	SQ	8/6/21	Merck				
	MCV4 (Meningococcal)	IM	8/6/21	Sanofi				
	MenB	IM	8/6/21	GSK				
	PCV15 Pneumococcal (conjugate)	IM	5/12/23	Merck				
	PCV20 Pneumococcal (conjugate)	IM	5/12/23	Pfizer				
	Rotavirus	PO	10/15/21	Merck				
	RSV (Respiratory Syncytial Virus)	IM	7/24/23	Pfizer GSK				
	Tdap	IM	8/6/21	Sanofi				
	Varicella (Chickenpox)	SQ	8/6/21	Merck				
	Zoster (Recombinant) Shingles	IM	2/4/22	GSK				
	IIV (Inactivated Influenza Vaccine)	IM	8/6/21	GSK Sanofi Sanofi – HD Seqirus				
	COVID-19	IM	EUA Varies	Moderna Pfizer				

Assessment/Teaching: _____

Nurse's Signature **Date**

COMMENTS: (Include exemptions, contraindications, informed refusals and "Contact" vaccination information)

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