VACCINE ADMINISTRATION RECORD – INFLUENZA AND FALL RESPIRATORY

Lake Region District Health Unit
524 4th Ave NE, Unit 9
Devils Lake, ND 58301

___Benson Co. Clinic #4 ___Eddy Co. Clinic #16 ___Pierce Co. Clinic #30 ___ Ramsey Co. Clinic #31

Public Health
Prevent. Promote. Protect.

Information collected on this form will be used to document authorization of receipt of vaccine(s). Information 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.

Patient's Name (Last, First & Middle Initial)**:**		**Date of Birth:**	**Age:**	**Gender:** ☐ **Male** ☐ **Female**
Address:	**City:**	**County:**	**State:**	**Zip Code:**
Primary Phone Number:	**Cell Phone Number:**	**Race:**	**Ethnicity:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown	
Birthplace:	**Name of Parent / Legal Guardian:**	**Mother's Information** (Last, First, Middle & Maiden)**:**		

Electronic Contact Consent: ☐ Text ☐ Email Address_____

VFC Eligibility Status: ☐ Medicaid ☐ Native American ☐ Underinsured -Vaccines **NOT COVERED** by health insurance
Check all that apply ☐ No Insurance ☐ Insured -Vaccines **COVERED** by health insurance

PRIMARY INSURANCE POLICY HOLDER INFORMATION

Last Name_____ **First Name**_____ **Middle Initial**_____

Date of Birth_____ **Gender** ☐ Male ☐ Female **Policy Holder Relationship to Client** _____

Primary Insurance Company Name_____

Policy Number_____ **Do you have a secondary insurance policy? ☐ Yes ☐ No**

HEALTH CHECK LIST

☐ Daily Medications ☐ Allergies ☐Previous Vaccine Reaction ☐ History of lung, heart, kidney, metabolic disease or blood disorder ☐ Seizures or other brain/nervous system problems ☐ History of cancer, leukemia, HIV/AIDS or other immune system problems ☐ Past year use of antiviral drugs or transfusion of blood products ☐ Past 3 months taken any medications that weaken immune system ☐ Received any vaccines in past 4 weeks ☐ Pregnant ☐ Other medical condition

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I acknowledge that I may request a copy of the Local Public Health Unit's Notice of Privacy Practices. I authorize the release of any medical or other information necessary to process this claim. 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). 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

X_____ _____

SIGNATURE OF PATIENT OR PARENT / LEGAL GUARDIAN **DATE (Valid for 1 year)**

HEALTH SCREENING REVIEWED / APPROVED ☐ Yes ☐ No

✓	Vaccine(s) /VIS To Be Given	Rx ✓	VIS Date	Mfr.	Cost	CPT Code	Lot Number	Admin Site	Nurse Initial	NN ✓
	Covid-19 2024-2025					Z23				
	Moderna 12+		10/19/2023	Moderna	$160.50	91301				
	Moderna Pediatric		10/19/2023	Moderna	$160.50	91321		LA RA		
	Pfizer 12+		10/19/2023	Pfizer	$150.50	90305		LT RT		
	Pfizer Pediatric		10/19/2023	Pfizer	$110.50	91319				
	Influenza			SP AVP		Z23				
	Trivalent IIV3		08/06/2021	Sanofi GSK	$40.50	90657		LA RA		
	Influenza High Dose 65+		08/06/2021	Sequirus	$73.50	90662		LT RT		
	Influenza Nasal (Flumist)		08/06/2021	Medimmune	$43.00	90660		IN		
	PCV-20 Pneumococcal Conjugate		05/12/2023	Pfizer	$300.50	Z23 90677		LA RA		
	RSV Arexvy		10/19/2023	GSK	$330.50	Z23 90679		LA RA		

Revised 07/01/2024 **Nurse's Signature** _____ **Date**_____