VACCINE ADMINISTRATION RECORD – SCHOOL INFLUENZA CLINIC

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**

SCREENING CHECK LIST (please mark all that apply)

☐ Is the person to be vaccinated currently sick? ☐ Has the person ever had a reaction to the influenza vaccine?
☐ Is the person allergic to any of the ingredients in the vaccine? ☐ Has the person ever had Guillain-Barre` Syndrome?
☐ Has the person ever felt dizzy or fainted before or after a shot? ☐ Does the person have anxiety about getting vaccinated?
☐ Does the person have any long-term health conditions? ☐ Past 3 months taken any medications that weaken immune system?
☐ Received any vaccines in past 4 weeks? ☐ Does the person wheeze or have asthma? ☐ Other medical condition

☐ Influenza Injection OR ☐ Influenza Nasal Mist

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I acknowledge that I may request a copy of Lake Region District 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 Lake Region District 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 Lake Region District Health Unit of all benefits payable for the Client's care.

X_____ _____

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

OFFICE USE ONLY: **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 ✓
	Influenza					Z23				
	IIV3 P/F		08/06/2021	GSK Sanofi	$40.50	90656 90661		LA RA		
	IIV3 P/F (High Dose 65+)		08/06/2021	Sanofi Seqirus	$85.50	90662 90653		LT RT		
	LAIV3 (Nasal)		08/06/2021	Astra Zeneca	$43.00	90660		IN		

Administration fee $50.50
Revised 09/04/2024

Nurse's Signature _____ **Date**_____