VACCINE ADMINISTRATION RECORD

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

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:
Check all that apply

☐ Medicaid ☐ Native American
☐ No Insurance ☐ Underinsured -Vaccines **NOT COVERED** by health 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 ☐

Please Detail Checked Information:

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)**

Revised 06/24/2024

Health Screening Reviewed / Approved   Yes_______   No______   Date Administered ____________________________

✓	Vaccine(s) /VIS To Be Given	Rx ✓	VIS Date	Mfr.	Cost	CPT Code	Lot Number	Admin Site	Nurse Initial	NN ✓
	COVID-19 2023-2024					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				
	DTaP diphtheria-tetanus-pertussis		10/15/2021	GSK AVP	$45.50	Z23 90700		LA RA LT RT		
	DTaP/HBV/IPV (Pediatrix)		07/24/2023	GSK	$115.50	Z23 90723		LT RT		
	DTaP/Hib/IPV (Pentacel)		10/15/2021	Sanofi	$130.50	Z23 90698		LT RT		
	DTaP / IPV (Kinrix)		10/15/2021	GSK	$85.50	Z23 90696		LA RA LT RT		
	HAV Hepatitis A 12 mo thru 18 years		10/15/2021	GSK	$60.50	Z23 90633		LA RA LT RT		
	HAV Hepatitis A 19 years & Older		10/15/2021	GSK	$95.50	Z23 90632		LA RA		
	HBV Hepatitis B Birth thru 19 years		05/12/2023	GSK	$45.50	Z23 90744		LA RA LT RT		
	HBV Hepatitis B 20 years & Older		05/12/2023	GSK	$85.50	Z23 90746		LA RA		
	Hib					Z23				
	Act-Hib		08/06/2021	AVP	$35.50	90648				
	Pedvax Hib		08/06/2021	MSD	$45.50	90647		LT RT		
	HPV-9 Human Papilloma Virus		08/06/2021	MSD	$320.50	Z23 90651		LA RA		
	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		
	IPV Inactivated Polio Virus		08/06/2021	AVP	$55.50	Z23 90713		LA RA LT RT		
	Men B (Bexsero)		08/06/2021	GSK	$260.50	Z23 90620		LA RA		
	MMR Measles-Mumps-Rubella		08/06/2021	Merck	$115.50	Z23 90707		LA RA LT RT		
	MMRV Measles-Mumps-Rubella-Varicella		08/06/2021	Merck	$305.50	Z23 90710		LA RA LT RT		
	MCV-4 Meningococcal Conjugate		08/06/2021	GSK AVP	$180.50	Z23 90734		LA RA		
	PCV-20 Pneumococcal Conjugate		05/12/2023	Pfizer	$300.50	Z23 90677		LA RA LT RT		
	Rotavirus (Rotarix)		10/19/2021	GSK	$160.50	Z23 90681		PO		
	RSV					Z23				
	Arexvy		10/19/2023	GSK	$330.50	90679		LA RA		
	Nirsevimab-alip 0.5 ml		10/19/2023	AVP	$350.50	90380		LT RT		
	Nirsevimab-alip 1 ml		10/19/2023		$350.50	90381				
	Tdap tetanus-diphtheria-pertussis		08/06/2021	GSK	$70.50	Z23 90715		LA RA		
	Varicella Chickenpox		08/06/2021	Merck	$205.50	Z23 90716		LA RA LT RT		
	Zoster Shingles (Shingrix)		02/04/2022	GSK	$220.50	Z23 90750		LA RA		

1. Route: IM = Intramuscular, SQ = Subcutaneous, IN = Intranasal, PO = Oral ID= Intradermal
2. Manufacturer: AVP = Sanofi Pasteur (aventis), GSK = GlaxoSmithKline, MBL = Massachusetts Biological Laboratories, MSD = Merck & Co., WAL = Wyeth
3. Site Vaccine Given: LA = Left Arm, RA = Right Arm, LT = Left Thigh, RT = Right Thigh
4. Exemption or Contraindication: MED = Medical, REG = Religious, PHIL = Philosophical, MOR = Moral, HOD = History of Disease (Please indicate date of exemption, contraindication or disease) *Exemption or Contraindication Note__________________

Nurse's Signature ____