CAVALIER COUNTY HEALTH DISTRICT VACCINE ADMINSTRATION RECORD

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Tax ID Number: 45-0427926 NPI Number: 1174566335

Questions 1 – 4 are used to determine if children 18 years of age or younger qualify for a federally funded immunization program titled Vaccine for Children.

□ Yes □ No □ Unknown **1.** Is your child enrolled in Medicaid?

□ Yes □ No □ Unknown **2.** Does your child have private health insurance?

□ Yes □ No □ Unknown **3.** Does your child's private health insurance cover vaccinations?

□ Yes □ No **4.** Is your child Native American or Alaskan Native?

PLEASE PRINT INFORMATION ABOUT PERSON TO RECEIVE VACCINE

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

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

Insurance Policy Number	**Medicare/Medicaid 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.

SCREENING QUESTIONS FOR PERSON RECEIVING THE VACCINE:

1. Has the client had a previous flu vaccine? Yes No
2. Is the person to be vaccinated sick today? Yes No
3. Does the person to be vaccinated have an allergy to a component of the vaccine? Yes No
4. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? Yes No
5. Has the person to be vaccinated ever had Guillain-Barre syndrome? Yes No
6. Are you currently using tobacco? Yes No
7. Are you exposed to second hand smoke? Yes No
8. Do you have a chronic disease condition? (such as; heart or lung disease, diabetes, immune suppressed, no spleen)? Yes No

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- Person to receive vaccine or person authorized to sign on the client's behalf:	**Date:**

Office Use Only

	Vaccine(s) To Be Given	**Route**	**VIS Date**	**MGF**	**Lot Number**	**S/P**	**Site**	**Vaccine Administrator**
	IIV (Inactivated Influenza Vaccine)	IM	08/15/19	SP-Fluzone NOV-Fluvirin GSK – Fluarix				
	IIV3 High Dose (Influenza vaccine)	IM	08/15/19	SP				
	PCV13 Prevnar	IM	11/05/15	Pfizer				
	PPV23 Pneumovax	IM	04/24/15	MSD				
	Td/Tdap	IM	Tdap 02/24/15 Td 04/11/2017	SP				

Billed To: ____________ **Amount Billed:** ______________ **Date Billed:** ______________ **Date Paid:** ______________ **08/19**