CAVALIER COUNTY HEALTH DISTRICT VACCINE ADMINSTRATION RECORD

901 3rd St, Suite 11, Langdon, ND 58249, Phone: (701) 256-2402, Fax: (701) 256-5765
Tax ID Number: 45-0427926 NPI Number: 1174566335

Client's Name (Last, First, Middle Initial):	**Date of Birth:**	**Age:**	**Grade**	**School**
Address (Street or P.O. Box):	**City:**	**State:**	**Zip Code:**	
Home phone number:	**Emergency phone number:**			

Please check all that apply regarding your child:

________American Indian or Alaskan Native

________Has Medicaid – I.D. number:____________________________________

________Has NO medical insurance or insurance does not cover immunizations.

________Has medical insurance. Insurance company name:____

Policy number:____

Name of Policy Holder:_________________________________Date of Birth:___________
Address (if different than above):____
____

Influenza Screening Questions

	Please Check Appropriate Box	YES	NO
1.	Has your child received a flu vaccination before?		
2.	Has your child had a serious reaction to a previous dose of influenza vaccine?		
3.	Has your child had a serious allergic reaction to eggs or to a component of the influenza vaccine?		
4.	Has your child ever had Guillain-Barre syndrome?		

☐ **I** will not be present with my child during the Immunization Clinic.

☐ I wish to be present when my child is vaccinated. (Arrangements will be made with parent)

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

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.

X____ ________________________
SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

FOR CLINIC USE ONLY

Date of Vaccination: ________________

X	Vaccine(s) to be given	VIS Date	Manufacturer	Lot Number	Dosage	Admin Site	Nurse Signature
	IIV Inactivated Flu Vaccine	08/15/19	NOV-Fluvirin GSK-Fluarix SP-Fluzone		0.5 ml	LA RA	

Billed To: ______________________________________

Amount Billed: ____________________________________

Date Billed: ____________________________________

Date Paid: ____