VACCINE ADMINISTRATION RECORD

Foster County Public Health

881 Main Street, Carrington, ND 58421
(701)652-3087

Clinic ID Number 46

Print Patient's Name (Last, First, Middle Initial):		Date of Birth:	Age:	Gender: ☐ Male ☐ Female
Preferred Pronoun: He,Him,His She,Her,Hers They,Their,Them No Preference Other _____				
Address (Street or PO Box):	City:	County:	State:	Zip Code:
Home Phone #	Cell #	Work #		
Maiden Name or Alias:	RACE: Asian African American White Native Hawaiian or Other Pacific Islander Hispanic/Latino Other: _____	Birth State/Country: _____		
Name of Responsible Financial Party:	Address if different from Patient's address:			

☐ **Native American** ☐ **Alaskan Native** ☐ **No Insurance** ☐ **Underinsured (Vaccines not covered by health insurance)**
☐ **Insured (Vaccines covered by health insurance – Not VFC eligible)** ☐ **Medicaid**

Screening Questions for the person getting vaccinated

Are you sick today?	☐YES ☐NO ☐DON'T KNOW
Do you have allergies to medications, food, a vaccine component, or latex? List:	☐YES ☐NO ☐DON'T KNOW
Have you ever had a serious reaction after receiving a vaccination?	☐YES ☐NO ☐DON'T KNOW
Do you have a long-term health problem with heart disease, lung disease, (e.g., asthma), kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), anemia or another blood disorder?	☐YES ☐NO ☐DON'T KNOW
Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐YES ☐NO ☐DON'T KNOW
Have you had a seizure, brain or other nervous system problems including Guillain-Barre (paralyzing polio)?	☐YES ☐NO ☐DON'T KNOW
During the past year, have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug?	☐YES ☐NO ☐DON'T KNOW
For women: Are you pregnant/Is there a chance you could become pregnant in the next month?	☐YES ☐NO ☐DON'T KNOW
Have you received any vaccinations in the past 4 weeks?	☐YES ☐NO ☐DON'T KNOW
Have you had shingles within the last year?	☐YES ☐NO ☐DON'T KNOW
In the past 3 months, have you taken medication that affects your immune system such as prednisone, other steroids, or drugs for the treatment of cancer, rheumatoid arthritis, Crohn's disease, psoriasis or had radiation treatment?	☐YES ☐NO ☐DON'T KNOW
Do you currently smoke, chew, vape or have exposure to secondhand smoke?	☐YES ☐NO ☐DON'T KNOW
Are you a prior ☐smoker, ☐chewer, ☐electronic nicotine user? Quit date: _____ Quitline Referral Accepted Yes☐ N/A☐ Referral Refused ☐	☐YES ☐NO ☐DON'T KNOW

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.

Please initial & SIGN ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

_____ I authorize the release of any medical or other information necessary to process this claim. I consent to data entry into the NDIIS (North Dakota Immunization Information System - state vaccine registry.

_____A copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Statement(s) (VIS) 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). ☐ Patient refused VIS

_____ If I am the Patient, or an individual legally obligated to pay for medical services provided to the Patient 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 Patient's care. (Minor not allowed to sign)

X_____ _____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PERSON RELATIONSHIP TO PATIENT DATE

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NAME_____ **Date of Birth** _____

Date/Time Vaccine Administered: **Date of Injury:** _____

☐ **Did not wait 15 minutes**

✗	Vaccine(s) To Be Given	VIS Date	Mfr.	Lot Number	Route	Admin. Site	Nurse Signature
	DTaP (Diphtheria-Tetanus-Pertussis)	7/24/23	GSK		IM	R Upper Arm L Lower Thigh	
	DTaP/IPV (Kinrix)	7/24/23	GSK		IM	R Upper Arm L Lower Thigh	
	DTaP/HBV/IPV/HIB (Vaxellis)	7/24/23	GSK		IM	R Upper Arm L Lower Thigh	
	Hepatitis A Ped/Adol Adult	1/31/25	GSK		IM	R Upper Arm L Lower Thigh	
	Hepatitis B Ped/Adol Adult	1/31/25	GSK		IM	R Upper Arm L Lower Thigh	
	Hib (Haemophilus influenzae B)	7/24/23	MSD		IM	R Upper Arm L Lower Thigh	
	HPV-9 Human Papillomavirus	8/6/21	MSD		IM	R Upper Arm L Lower Thigh	
	Influenza 0.5ml MDV or PFS	1/31/25	SFP		IM IN	R Upper Arm L Lower Thigh	
	IPV (Polio)	1/31/25	SFP		IM	R Upper Arm L Lower Thigh	
	MMRV (Measles-Mumps Rubella-Varicella	1/31/25	MSD		IM	R Upper Arm L Lower Thigh	
	MCV-4 (Meningococcal Conjugate)	1/31/25	SFP		IM	R Upper Arm L Lower Thigh	
	PCV-20 (Pneumococcal Conjugate)	5/29/25	PFZ		IM	R Upper Arm L Lower Thigh	
	Varicella (Chickenpox)	1/31/25	MSD		IM	R Upper Arm L Lower Thigh	
	Men-B (Meningococcal group B)	1/31/25	WAL		IM	R Upper Arm L Lower Thigh	
	Rotavirus	10/15/21	MSD		PO	Oral	
	TDaP (Tetanus-Diphtheria-Pertussis)	1/31/25	GSK		IM	R Upper Arm L Lower Thigh	
	MMR (Measles, Mumps, Reubella)	1/31/25	MSD		IM	R Upper Arm L Lower Thigh	
	Shingles (Zoster) Dose 1 Dose 2	2/4/22	GSK			R Upper Arm L Lower Thigh	

1. Route: IM = Intramuscular, SQ = Subcutaneous, IN = Intranasal, PO = Oral
2. Manufacturer: SFP = Sanofi Pasteur, GSK = GlaxoSmithKline, MSD = Merck & Co., PFZ= Pfizer, 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

REV: 7/24/2025