VACCINE ADMINISTRATION RECORD
Foster County Public Health
881 Main Street, Carrington, ND 58421
(701)652-3087

☐ See Spanish VAR LABEL
☐ N/A

Clinic ID Number: 46

Patient's First Name:	Patient's Middle Name:	Patient's Last Name:
Maiden Name or other Aliases:		Race: (Check Box) ☐White ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian (Other Pacific Islander) ☐ Other _____
Age: / Birthdate: / Gender: ☐Male ☐Female		
Primary Telephone No.: / Telephone Number Type: ☐Home ☐Mobile ☐Work / Hispanic or Latino: ☐Yes ☐No		
Address (Street or P.O. Box):	City:	State: / ZIP Code:
County of Residence:	Birth State: Birth Country:	Email:
Emergency Contact Name:	Emergency Contact Relationship:	Emergency Contact Phone:

Insurance Information

☐VFC ELIGIBLE ☐VFA ELIGIBLE	☐NOT VFC ELIGIBLE ☐ ☐NOT VFA ELIGIBLE
☐ Alaskan Native ☐ No Insurance ☐ Underinsured (Vaccines not covered by insurance) ☐ Native American ☐ Medicaid # : _____	☐ Insured Name/State of Origin Insurance: _____

Insurance Policy Holder: First Name: _____ Middle Name: _____
Last Name: _____ Birthdate: _____ Relationship to Patient: _____
Insurance Policy #: _____ Policy Holder: Address same as client? ☐ Yes ☐ No
If different, please provide_____

Screening Questions for the person to be vaccinated

Are you sick today?	☐YES ☐NO ☐UNKNOWN
Do you have allergies to medications, food, a vaccine component, or latex? List:	☐YES ☐NO ☐UNKNOWN
Have you ever had a serious reaction after receiving a vaccination?	☐YES ☐NO ☐UNKNOWN
Do you have a long-term health problem with heart, lung, kidney, liver, nervous system, or a metabolic disease (e.g., diabetes), asthma (or wheezing in the past 12 months), a blood disorder, no spleen, a cochlear implant, a spinal fluid leak or receiving aspirin or salicylate medications?	☐YES ☐NO ☐UNKNOWN
Does the person to be vaccinated, their parents, sibling(s) or someone they have close contact with have cancer, leukemia, HIV/AIDS, or any other immune system problem or immunocompromising condition?	☐YES ☐NO ☐UNKNOWN
In the past 6 months, have you taken medication(s) that affect the 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 ☐UNKNOWN
Does the person to be vaccinated, their parents or sibling(s) had a seizure, brain or other nervous system problems including Guillain-Barre Syndrome (paralyzing polio)?	☐YES ☐NO ☐UNKNOWN

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In the past year, have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug (including influenza antiviral in the past 3 weeks)?	☐YES ☐NO ☐UNKNOWN
Have you ever been diagnosed with a heart condition (e.g., myocarditis) or had Multisystem Inflammatory Syndrome (MIS-A/C) after an infection with the virus that causes COVID-19?	☐YES ☐NO ☐UNKNOWN
Are you pregnant or could you become pregnant within the next 3 months?	☐YES ☐NO ☐UNKNOWN
Have you received any vaccinations in the past 4 weeks?	☐YES ☐NO ☐UNKNOWN
Are you currently experiencing an acute episode of herpes zoster (e.g., Shingles)?	☐YES ☐NO ☐UNKNOWN
For babies: Have you ever been told the child had intussusception?	☐YES ☐NO ☐UNKNOWN
Do you currently smoke, chew, vape, use any nicotine containing products or have exposure to secondhand smoke? **Is referral accepted to help quit nicotine: ☐Yes ☐N/A ☐Referral Refused**	☐YES ☐NO ☐UNKNOWN
Are you a prior ☐smoker, ☐chewer, ☐electronic nicotine user, ☐ any nicotine containing product user? **Quit date:**	☐YES ☐NO ☐UNKNOWN

CONSENT/ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS
(Please initial the 3 lines below and then sign at the bottom of the page)

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

_____A copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Statement(s) (VIS) or the Emergency Use Authorization (EUA) Fact sheet has been provided. I have read, or have had explained, the information about the disease(s) and the vaccine(s) listed. 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) be given to me or to the person named above (for whom I am authorized to make this request).

_____ 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 patient 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**

Patients Name:	**Birthdate:**