Public Health
Prevent. Promote. Protect.
Central Valley Health District

CENTRAL VALLEY HEALTH DISTRICT
ADULT VACCINE ADMINSTRATION RECORD (VAR)

122 Second Street NW, Jamestown ND 58401, Phone: (701) 252-8130
Logan County Courthouse, 301 Broadway, Napoleon ND 58561 phone: (701)754-2756

Client's Name (Last, First, Middle Initial):	Date of Birth:	Age:	Home Telephone Number:	
Address (Street or P.O. Box):	City:	County:	State:	Zip Code:

Circle all insurance plans you have:

Medicare **ND Medical Assistance** **Blue Cross** **Sanford** **Other :**_____

List all Policy or ID Numbers:	List all Group Numbers:
Name of Policy Holder:	Date of Birth of Policy Holder:

Race: White African American Amer. Indian Asian Other	**Hispanic Origin:** Yes No	**Male** **Female**
Do you use tobacco products? Yes No	**Are you exposed to second hand smoke?** Yes No	

THE FOLLOWING SCREENING QUESTIONS ARE TO DETERMINE WHICH INFLUENZA VACCINE YOU QUALIFY FOR.

Yes No 1. Have you had a serious reaction to latex, food, medications, or any vaccines?
Yes No 2. Do you have a history of Guillain-Barre (French Polio)?
Yes No 3. Have you had a previous reaction to a flu shot?
Yes No 4. Are you pregnant?
Yes No 5. Have you received any live vaccines in the past 30 days?
Yes No 6. Do you have a chronic disease?
Yes No 7. Are you sick today?

MY SIGNATURE BELOW INDICATES AUTHORIZATION, ACKNOWLEDGMENT, AND ASSIGNMENT OF INSURANCE BENEFITS:

- Information collected on this form will be used to document authorization for receipt/declination of vaccine(s). Information may be shared through the North Dakota Immunization Information System (NDIIS) with other entities. ND Century Code 23-01-05.3.
- I authorize the release of any medical or other information necessary to process this claim.
- I acknowledge that CVHD has provided me with their Notice of Privacy Practices. I understand I may request a copy of the Notice.
- If I am the client, or an individual legally obligated to pay for medical expenses provided to the client or a Guarantor of payment, I assign and authorize any third party payer/insurer to make direct payment to CVHD of all benefits payable for the client's care.
- I have read, or have had explained, the Vaccine Information Statement(s) about the vaccine(s) recommended and the disease(s) for which they provide protection. There was an opportunity to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) discussed and ask that those vaccine(s) be given to me or the person for whom I am authorized to make this request.
- I understand the CVHD participates in the NDHIN. I understand that participation is voluntary and if I choose to opt out I must complete the NDHIN Opt Out/Revoke Opt Out form

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

CLINIC USE ONLY

Vaccine To Be Given	Route	VIS Date	Write in info or place sticker here	Admin Site	Vaccine Administrator
Live Influenza Flumist (2-49 yrs)	IN	8/07/2015			
Inactivated Influenza Injection	IM	8/07/2015			
Signature and Title of Person Administering Vaccine:			**Date Vaccine was Administered:**		