DICKEY COUNTY HEALTH DISTRICT VACCINE ADMINSTRATION RECORD

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Public Health
Prevent. Promote. Protect.
Dickey County Health District

THESE QUESTIONS ARE TO BE ANSWERED BY THE PERSON RECEIVING THE VACCINE OR PARENT/GUARDIAN MAKING THE REQUEST.

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 (VFC).

□ 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 at Dickey County Health District?
□ Yes	□ No		**4.** Is your child Native American or Alaskan Native?

Date of Service:

PLEASE PRINT INFORMATION ABOUT PERSON TO RECEIVE VACCINE.

Client's Name	**Date of Birth:**	**Age:**	**Male**	**Female**
Address (Street or PO Box):	**City:**	**County:**	**State:**	**Zip Code:**
Telephone Number: / **ND Medicaid Number:**	**Hispanic Origin: Yes No**	**Email:**		
Name of Primary Insurance Company:	**Name of Policy Holder:**	**Policy Holder Date of Birth:**		
Insurance Policy Number:	**Is the Patient exposed to second hand smoke? Yes No**	**Race: White African American Asian American Indian Other**		
Is the patient using tobacco products? Yes No				

DOES THE PERSON RECEIVING THE VACCINE:			**SCREENING QUESTIONS**
□ Yes	□ No	□ Unknown	**1.** had any problems after receiving previous vaccines?
□ Yes	□ No	□ Unknown	**2.** have any allergies to food, latex, medicine, or any vaccine?
□ Yes	□ No	□ Unknown	**3.** have any neurological disorders or ever had a seizure or Guillain-Barre syndrome?
□ Yes	□ No	□ Unknown	**4.** have any problems with his/her immune system, such as cancer, leukemia, or HIV/AIDS?
□ Yes	□ No	□ Unknown	**5.** taken cortisone, prednisone, other steroids, or anti-cancer drugs, or x-ray treatments in the past 3 months?
□ Yes	□ No	□ Unknown	**6.** received any blood products or Immune Globulin in the past year?
□ Yes	□ No	□ Unknown	**7.** have a long-term health problem such as: heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?
□ Yes	□ No	□ Unknown	**8.** received ChickenPox vaccine (Varicella) or Measle Mumps Rubella (MMR) in the past four weeks?
□ Yes	□ No	□ Unknown	**9.** Is the person who is receiving the vaccine pregnant?
□ Yes	□ No	□ Unknown	**10.** Is the person receiving the vaccine sick today?

ACKNOWLEGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS
(Please read and sign below)

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 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 DCHD 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 oligated to pay for medical expenses provided to the client of a Guarantor of payment, I assign and authorize any third party payer/insurer to make direct payment to DCHD 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.

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