City-County Health District (3) Vaccine Administration Record (VAR)
415 2nd Ave NE, Ste. 101, Valley City, ND 58072-3060 Phone: 701-845-8518

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.

Print Patient's Legal Name (Full Last, First, Middle Name):	Maiden Name	Date of Birth:	Age:	Gender: ☐ Male ☐ Female
Address (Street or PO Box):	City:	County:	State:	Zip Code:
Primary Phone #	Work Phone#	Birth State (or list country if not US)		

Race: (check all that apply)
__ White __ American Indian or Native Alaskan
__ Asian __ Native Hawaiian or Other Pacific Islander
__ Black or African American

Hispanic or Latino Yes No

Mother's Information **(if client is age 18 or younger)**
Name: _____
Last First Middle
Mother's Maiden Name **(Required for children for ND immunization registry.)** _____

Name of Responsible Financial Party:	Address **if different** from patient's address:	Previous COUNTY of Residence:

INSURANCE INFORMATION □ ***NO INSURANCE (Check if applies.)***

****Name as it appears on insurance card:** _____

PLEASE NOTE: CCHD cannot Accept United Healthcare Insurance for immunizations.

Medicare Part B #_____ **Medicaid #** _____

Other Insurance: Primary Insurance Name and Address: _____
_____ Phone #:_____

Policy Number: _____ Group Number (if applicable): _____ Payer ID (if applicable): _____

Policy Holder's Last Name:_____ First Name_____ Middle Initial_____

Date of Birth: _____ Gender ☐ Male ☐ Female Policy Holder Relationship to Client: _____

Secondary Insurance (if applicable):_____

For School Clinics: School: _____ Grade: _____ Teacher: _____

The following questions refer to the person receiving the vaccination today:

1. Y N Is the person to be vaccinated sick today?
2. Y N Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?
3. Y N Does the person to be vaccinated have an allergy to eggs, meds, vaccine or latex? Describe_____
4. Y N Has the person to be vaccinated ever had Guillain Barre syndrome (French Polio)?
5. Y N Is the person to be vaccinated pregnant?

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I hereby authorize City-County Health District to release any information concerning my visit here to process any third-party claim. 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 Client's care. I give my permission for CCHD to administer the vaccines noted on the bottom of this consent form. I acknowledge receipt of CCHD's "Notice of Privacy Practices."

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. 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 be given to me or to the person named above (for whom I am authorized to make this request).

X_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PERSON (Must be 18 or older.) **DATE**

FOR OFFICE USE ONLY: (Form Rev. 9-19)

AAR
Tobacco Use: Y / N **Advised to Quit: Y / N** **Referred: Y / N** **Secondhand Smoke Exposure: Y / N**

S/P	Fluarix Quad 0.5 ml - PFS (6 mon. & up)	8/15/19	GSK		IM	LA RA LT RT		
S/P	Flucelvax Quad 0.5 ml – PFS (state ADT 19+)	8/15/19	SQ		IM	LA RA LT RT		
S/P	Fluzone Quad 0.5 ml – PFS (6 mon. & up)	8/15/19	SP		IM	LA RA LT RT		
S/P	Fluzone **HD** Quad 0.7 ml – (65 & up)	8/15/19	SP		IM	LA RA LT RT		
S = State / P = Private (circle) Vaccine		*VIS*	*Mfr*	*Lot*	*Rte.*	*Site*	*Nurse Signature*	*Date*

____ ***NDIIS*** ***Patagonia***: _____ *Registered* _____ *Nurse Documentation* _____ *Scanned*