Public Health
Prevent. Promote. Protect.

SOUTHWESTERN DISTRICT HEALTH UNIT

227 16th Street West, Dickinson, ND 58601

Vaccine Administration Record

Client's Last Name | Client's Legal First Name | M.I. | Other / Maiden Name | M F Gender (circle)

Client's Date of Birth | Client's Age | Client's Birth State | Mother's Name (if under 18)

Address (Street or PO Box) | City | State | Zip

Home Phone Number | Cell Phone Number | Work Phone Number | Primary Care Provider

Person Financially Responsible for Client | Relationship to Client | Address if different from Client's address

***Tobacco Use:**
- ☐ Current
- ☐ Former
- ☐ Never

Secondhand Smoke:
- ☐ Exposed
- ☐ Not Exposed

Advised to Quit:
- ☐ Yes
- ☐ No
- ☐ NA

Referral Offered:
- ☐ Yes
- ☐ No

Referral Accepted:
- ☐ Yes
- ☐ No

Race:
- ☐ White
- ☐ Black
- ☐ American Indian
- ☐ Asian
- ☐ Native Hawaiian

Ethnicity:
- ☐ Not Hispanic
- ☐ Hispanic

Language Preferred:
- ☐ English
- ☐ Spanish
- ☐ Other: _____

VFC Eligibility Status (check all that apply):
- ☐ ND Medicaid
- ☐ American Indian
- ☐ No Insurance
- ☐ Underinsured
- ☐ Not Eligible - (Vaccines covered by Health Insurance, Adult, etc.)

Do you have private insurance that covers immunizations? ☐ **Yes** ☐ **No**

Primary Insurance Provider:
- ☐ Blue Cross Blue Shield **State** _____
- ☐ Sanford Health Plan
- ☐ Sanford Medicaid Expansion
- ☐ ND Medicaid # _____
- ☐ Medicare # _____
- ☐ RR Medicare # _____
- ☐ Other: _____

Insurance Policy Number: _____

Insurance Policy Subscriber's Name: _____

Subscriber's Date of Birth: _____

Relationship to Client:
☐ Self ☐ Parent ☐ Spouse Other: _____

Subscriber's Address (if different than client's) _____

I acknowledge that I have been provided with Southwestern District Health Unit's Notice of Privacy Practices. I understand that I may request an additional copy of this Notice. I agree that I am financially responsible for services provided and not covered by a third-party payer. I assign and authorize any third-party payer to make payment to SWDHU for all benefits that I am eligible for.

I authorize the release of any medical or other information necessary to process this claim.

The information collected on this form will be used to document authorization to receive vaccinations. Information may be shared through the ND Immunization Information System (NDIIS) with other entities in accordance with ND Century Code 23-01-05.3. A copy of the appropriate Center's for Disease Control & 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. I had an opportunity to ask questions which were answered satisfactorily. I understand the benefits and risks of these vaccine(s) and ask that the vaccine(s) listed be given to me or the person named above for whom I am authorized to make this request.

Signature of Client / Parent or Legal Guardian (if under 18) | Date

VACCINE ADMINISTRATION RECORD (Series - Child / Adolescent / Adult) ***Prices are subject to change without notice.***

Client's Name							Date Vaccine Administered				
✓	Vaccine(s) To Be Given	Codes	Vaccine Fee	VIS Date	POS	Mfr. (Circle)	Lot Number	Rte	Admin Site (cir)	Nurse Signature	VFC P
	Hep A (Hepatitis A) 12 mo thru 18 YO	Z23 90633	VFC - 20.99 P - $ 62.00	10/25/2011	71 Clinic	MSD GSK		IM	LA RA LT RT		P
	Hep A (Hepatitis A) Age 19 & Older	Z23 90632	P - $ 86.00	10/25/2011	71 Clinic	MSD GSK		IM	LA RA LT RT		P
	Hep B (Hepatitis B) Birth thru 18 YO	Z23 90744	VFC - 20.99 P - $ 58.00	2/2/2012	71 Clinic	GSK MSD		IM	LA RA LT RT		VFC P
	Hep B (Hepatitis B) 19 Year Olds	Z23 90744	P - $ 58.00	2/2/2012	71 Clinic	GSK MSD		IM	LA RA LT RT		P
	Hep B (Hepatitis B) Age 20 & Older	Z23 90746	P - $ 97.00	2/2/2012	71 Clinic	MSD GSK		IM	LA RA LT RT		P
	HPV-4 (Human Papillomavirus)	Z23 90649	VFC - 20.99 P - $ 202.00	5/7/2013	71 Clinic	MSD		IM	LA RA LT RT		VFC P
	HPV-9 (Human Papillomavirus)	Z23 90651	VFC - 20.99 P - $ 221.00	3/31/2016	71 Clinic	MSD		IM	LA RA LT RT		VFC P
	MCV-4 (Meningococcal)	Z23 90734	VFC - 20.99 P - $ 152.00	3/31/2016	71 Clinic	AVP		IM	LA RA LT RT		VFC P
	Twinrix (Hep A & B)	Z23 90636	P - $ 132.00	10/25/2011 2/2/2012	71 Clinic	GSK		IM	LA RA LT RT		P
	Td (tetanus-diphtheria)	Z23 90714	P - $ 54.00	2/24/2015	71 Clinic	AVP MBL		IM	LA RA LT RT		P
	Tdap (tetanus-diphtheria-pertussis)	Z23 90715	P - $ 65.00	2/24/2015	71 Clinic	AVP GSK		IM	LA RA LT RT		P

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	Hep A (Hepatitis A) Age 19 & Older	Z23 90632	P - $ 86.00	10/25/2011	71 Clinic	MSD GSK		IM	LA RA LT RT		P
	Hep B (Hepatitis B) Birth thru 18 YO	Z23 90744	VFC - 20.99 P - $ 58.00	2/2/2012	71 Clinic	GSK MSD		IM	LA RA LT RT		VFC P
	Hep B (Hepatitis B) 19 Years Old	Z23 90744	P - $ 58.00	2/2/2012	71 Clinic	GSK MSD		IM	LA RA LT RT		P
	Hep B (Hepatitis B) Age 20 & Older	Z23 90746	P - $ 97.00	2/2/2012	71 Clinic	MSD GSK		IM	LA RA LT RT		P
	HPV-4 (Human Papillomavirus)	Z23 90649	VFC - 20.99 P - $ 202.00	5/7/2013	71 Clinic	MSD		IM	LA RA LT RT		VFC P
	HPV-9 (Human Papillomavirus)	Z23 90651	VFC - 20.99 P - $ 221.00	3/31/2016	71 Clinic	MSD		IM	LA RA LT RT		VFC P
	Twinrix (Hep A & B)	Z23 90636	P - $ 132.00	10/25/2011 2/2/2012	71 Clinic	GSK		IM	LA RA LT RT		P

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1. Route: IM = Intramuscular, SQ = Subcutaneous, IN = Intranasal, PO = Oral 2. Manufacturer: AVP = Sanofi Pasteur (Aventis), GSK = GlaxoSmithKline, MBL = Massachusetts Biological Laboratories, MSD = Merck & Co., 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 Note_____

VFC/P: Indicates if state supplied or privately purchased. **VFC** = VFC eligible **P** = Privately purchased