Richland County Health Department
Prevent. Promote. Protect.

RICHLAND COUNTY HEALTH DEPARTMENT VACCINE ADMINISTRATION RECORD

413 3rd Ave. North, Wahpeton, ND 58075, Phone: (701) 642-7735, Fax: (701) 642-7746
Tax ID Number: 45-600-2236 NPI Number: 1275626053

Provider ID: 34

PLEASE PRINT INFORMATION ABOUT PERSON TO RECEIVE VACCINE.

Name: Last	**First**	**Middle**	**Birth Date:**	**Age:**	**State of Birth:**

Address (Street or P.O. Box):	**City:**	**State:**	**Zip Code:**

County:	**Gender at birth**	**Gender identity**	**Pronoun:**	**Primary Phone #:**
	□ Male □ Female □ Intersex	□ Male □ Female □ Non-Binary	□ He/His □ She/Her □ They/Them	

Race: (Check all applicable boxes) □ American Indian or Alaskan Native □ Asian □ Black or African American □ Native Hawaiian or Pacific Islander □ White

Ethnicity of client: (Check one box)
□ Hispanic or Latino
□ Not Hispanic or Latino

Name of Person Financially Responsible:	**Mother's Name (If client is 18 yrs or younger): Last, First, Middle**	**Mother's Maiden Name**

Primary Insurance Provider

□ BCBS □ ND Medicaid
□ Humana □ Medicare
□ Medica □ Sanford
□ Other_____
□ None

Policy ID Number:_____
Policy Holder Name:_____
Policy Holder Date of Birth:_____

Policy holder relationship to client:
□Self □ Parent
□Spouse □Other:_____

Secondary Insurance Provider

□ BCBS □ ND Medicaid
□ Humana □ Medicare
□ Medica □ Sanford
□ Other_____
□ None

Policy ID Number: _____
Policy Holder Name: _____
Policy Holder Date of Birth:_____

Policy holder relationship to client:
□Self □ Parent
□Spouse □Other:_____

Self-Pay: Amount Owed: _____ Amount paid: _____□ Check/Cash □ Credit card Receipt #: _____ Initials: _____

In the past 12 months we worried whether our food would run out or not last before we got money to buy more:
□ Often True □ Sometimes True □ Never True

Do you receive SNAP benefits: □ Yes □ No
If no, would you like RSR Human Services to send out an application □ Yes □ No

SCREENING QUESTIONS FOR ALL AGES

□ **Yes** □ **No** **I or my child have concerns or precautions to the vaccine(s) being administered, including but not limited to: allergies/reactions to medications, food, or vaccines, Guillain Barre, seizures, taking any corticosteroid medications i.e. Prednisone, cortisone injections, or problems with your immune system.**

□ **Yes** □ **No** **I have had a fever or been sick in the past two days.**

□ **Yes** □ **No** **I have received vaccines in the past 4 weeks or any blood products including monoclonal antibodies or Immune Globulins in the past year.**

MY SIGNATURE BELOW INDICATES:

1. 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, information about the disease(s) and the vaccine(s) listed below. 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 the person named (for whom I am authorized to make this request.)
2. Information collected on this form will be used to document authorization for receipt of vaccine(s). Information may be shared through the North Dakota Immunization Information System (NDIIS) with other entities in accordance with the ND Century Code 23-01-05.3.
3. I acknowledge the office of the Richland County Health Department has provided me with their Notice of Privacy Practices.
4. I authorize the release of any medical or other information necessary to process this claim.
5. 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 agree to pay and I am financially responsible for Richland County Health Department's established charges provided to the client not covered by a third-party payer.
6. I assign and authorize any third-party payer/insurer to make direct payment to Richland County Health Department of all benefits payable for the client's care.

I am between the ages 2 and 49 years of age and want FluMist if available (not available at all clinics/encounters) □ **Yes** □ **No**

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

NURSE TO COMPLETE

[1]	Vaccine(s) To Be Given		Route[2]	VIS Date	MGF[3] (Circle)	Lot Number	Exp. Date	S/P[4]	Admin Site[5]	Vaccine Admin.[6]
	COVID-19 (Moderna)	6mo – 11 yrs	IM	10/19/23	MOD				RA LA RT LT	
	COVID-19 (Moderna)	12yrs +	IM	10/19/23	MOD				RA LA RT LT	
	DTaP	6 wks thru 6 yrs	IM	08/06/21	SP GSK				RA LA RT LT	
	DTaP/IPV (Kinrix)	4 yrs thru 6 yrs	IM	07/24/23	GSK				RA LA RT LT	
	DTaP-IPV–HIB (Pentacel)	6 wks thru 4 yrs	IM	07/24/23	GSK				RA LA RT LT	
	Hep A (pediatric)	12 mo – 18 yrs	IM	10/15/21	M GSK				RA LA RT LT	
	Hep A (HAV adult)	19 yrs +	IM	10/15/21	M GSK				RA LA RT LT	
	Hep B (Hep B pediatric)	Birth – 18 yrs	IM	05/12/23	M GSK				RA LA RT LT	
	Hep B (adult)	Energix – B 20 yrs+	IM	05/12/23	M GSK				RA LA RT LT	
	HepA/HepB (Twinrix)	18 yrs +	IM	10/15/21 05/12/23	GSK				RA LA RT LT	
	Hib	2 mo. thru 5 years	IM	08/06/21	SP				RA LA RT LT	
	HPV9 (Gardasil)	9 yrs – 45 yrs	IM	08/06/21	M				RA LA RT LT	
	Influenza Inactivated **RIV3** (FluBlok18 yrs +) **IIV3** (6 mo +) **IIV3** (High Dose 65+) **IIV3** (FluLaval 6 mo +)**CCIIV3** (Flucelvax 6 mo +)		IM	08/06/2021	SP GSK SEQ				RA LA RT LT	
	IPV	6 wks and older	IM/SQ	08/06/21	SP				RA LA RT LT	
	MCV4 (Meningococcal) MenQuadfi	2yrs +	IM	08/06/21	SP				RA LA RT LT	
	Men B (Meningococcal B) Bexsero	10 yrs thru 23 yrs	IM	08/06/21	GSK				RA LA RT LT	
	MMR	12 mo +	IM/SQ	08/06/21	M				RA LA RT LT	
	MMRV	12 mo thru 12 yrs	IM/SQ	08/06/21	M				RA LA RT LT	
	PCV20 (Conjugate) Prevnar 20	2 mo +	IM	05/12/23	PFZ				RA LA RT LT	
	PPSV23 (polysaccharide) Pneumovax	2 yrs +	IM/SQ	10/30/19	M				RA LA RT LT	
	RSV (pediatric) up to 8 mo: <5 kg = 50 mg **OR** >5 kg = 100 mg **8 – 19 mo.** = **200mg (2 shots of 100mg)** **Administer between months of Sept – Jan.**		IM	10/19/23	SP				RA LA RT LT	
	RSV (adult)	75 yrs +	IM	10/19/23	PFZ				RA LA RT LT	
	RV rotavirus	6 wks up to 24 wks	PO	10/15/21	M GSK				PO	
	Tdap	10 yrs +	IM	08/06/21	SP GSK				RA LA RT LT	
	Varicella	12 mo +	IM/SQ	08/06/21	M				RA LA RT LT	
	Zoster (Shingrix)	50 yrs +	IM	02/04/22	GSK				RA LA RT LT	

1. Number of vaccine in series **2. Route:** IM = Intramuscular, SQ = Subcutaneous, PO = Oral, ID = Intradermal
3. Manufacturer: SP = Sanofi Pasteur, GSK = GlaxoSmithKline, M = Merck & Co., PFZ=Pfizer, MOD= Moderna, BN = Bavarian Nordic, AZ = AstraZeneca, SEQ = Seqirus
4. Indicate if state-supplied or privately purchased: S = State-supplied, P = Privately purchased
5.. Site Vaccine Given: RA = Right Arm, LA = Left Arm, RT = Right Thigh, LT = Left Thigh, LUA = Upper Left Arm, RUA = Upper Right Arm, LFA = Left Forearm, RFA = Right Forearm **6. Initials of person administering vaccine**

VFC (Vaccine for Children) Eligibility Status (Give state vaccine for ages 18 and younger)
- □ Is American Indian or Alaskan Native
- □ Has Medical Assistance/Medicaid
- □ Uninsured/Underinsured (vaccines not covered by health insurance) – Payor source – "Pay at time of visit"

Weight (if 18 or younger)

_____

actual or reported
Circle one

317 STATE VACCINE 19 and older **UNDERINSURED** and **UNINSURED -** Check vaccine binder for eligible vaccines
- □ Other state eligible or local state eligible - Payor Source is "pay at time of service"

PRIVATE VACCINE **INSURED CHILDREN** and **ADULTS**
- □ Not eligible - vaccines covered by Medica, BCBS, Sanford Health Plan insurance, Medicaid, or Medicare
- □ Not eligible - Richland County Health Department does not bill the insurance. _____ (name of insurance)
- □ Client desires to receive and pay for vaccine and receive a super bill - Payor Source is "self pay"
- □ Client desires to receive and pay for vaccine and declines a super bill - Payor Source is "self pay"

"A-A-R" – Tobacco Use & Exposure:
Tobacco user? Y N N/A Refuse
Advised to quit? Y N N/A
Referral offered? Y N N/A Refuse
Are you exposed to SHS? Y N R

Nurses Signature: _____ Date: _____

Agency Use: □ Data Entry into Champ/Thor □ Nurse/Billing Review □ Scanned into Champ