VACCINE ADMINISTRATION RECORD – INFLUENZA AND FALL RESPIRATORY

Lake Region District Health Unit
524 4th Ave NE, Unit 9
Devils Lake, ND 58301

___Benson Co. Clinic #4 __ _Eddy Co. Clinic #16 ___Pierce Co. Clinic #30 ___ Ramsey Co. Clinic #31

Public Health
Prevent. Promote. Protect.

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.

Patient's Name (Last, First & Middle Initial):		**Date of Birth:**	**Age:**	**Gender:** ☐ **Male** ☐ **Female**
Address:	**City:**	**County:**	**State:**	**Zip Code:**
Primary Phone Number:	**Cell Phone Number:**	**Race:**	**Ethnicity:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown	
Birthplace:	**Name of Parent / Legal Guardian:**	**Mother's Information** (Last, First, Middle & Maiden):		

Electronic Contact Consent: ☐ Text ☐ Email Address_____

VFC Eligibility Status: ☐ Medicaid ☐ Native American ☐ Underinsured -Vaccines **NOT COVERED** by health insurance
Check all that apply ☐ No Insurance ☐ Insured -Vaccines **COVERED** by health insurance

PRIMARY INSURANCE POLICY HOLDER INFORMATION

Last Name_____ **First Name**_____ **Middle Initial**_____

Date of Birth_____ **Gender** ☐ Male ☐ Female **Policy Holder Relationship to Client** _____

Primary Insurance Company Name_____

Policy Number_____ **Do you have a secondary insurance policy? ☐ Yes ☐ No**

HEALTH CHECK LIST (please mark all that apply)

☐ Daily Medications ☐ Allergies ☐Previous Vaccine Reaction ☐ History of lung, heart, kidney, metabolic disease or blood disorder ☐ Seizures or other brain/nervous system problems ☐ History of cancer, leukemia, HIV/AIDS or other immune system problems ☐ Past year use of antiviral drugs or transfusion of blood products ☐ Past 3 months taken any medications that weaken immune system ☐ Received any vaccines in past 4 weeks ☐ Pregnant ☐ Other medical condition

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I acknowledge that I may request a copy of Lake Region District Health Unit's Notice of Privacy Practices. I authorize the release of any medical or other information necessary to process this claim. 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 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 below be given to me or to the person named above (for whom I am authorized to make this request). If I am the Client, or an individual legally obligated to pay for medical services provided to the Client or a Guarantor of payment, I agree to pay and I am financially responsible for Lake Region District Health Unit's established charges provided to the Client not covered by a third-party payer. I assign and authorize any third-party payer/insurer to make direct payment to Lake Region District Health Unit of all benefits payable for the Client's care.

X_____ _____

SIGNATURE OF PATIENT OR PARENT / LEGAL GUARDIAN **DATE (Valid for 1 year)**

OFFICE USE ONLY: Revised 08/19/2025 **HEALTH SCREENING REVIEWED / APPROVED ☐ Yes ☐ No**

✓	Vaccine(s) /VIS To Be Given	Rx ✓	VIS Date	Mfr.	Cost	CPT Code	Lot Number	Admin Site	Nurse Initial	NN ✓
	COVID-19 2025-2026					Z23				
	Moderna Spikevax 12+		01/31/2025	Moderna	$180.50	91322				
	Moderna 6 mo – 11 yr		01/31/2025	Moderna	$180.50	91321		LA RA		
	Pfizer Comirnaty 12+		01/31/2025	Pfizer	$150.50	90320		LT RT		
	Pfizer 5 - 11 yr		01/31/2025	Pfizer	$100.50	91319				
	Pfizer < 5 yr		01/31/2025	Pfizer	$100.50	91318				
	In-Home Medicare Admin				$45.00	90480				
	Influenza					Z23				
	IIV3 P/F		01/31/2025	GSK Sanofi	$40.50	90656 90661		LA RA		
	IIV3 P/F (High Dose 65+)		01/31/2025	Sanofi Seqirus	$85.50	90662 90653		LT RT		
	LAIV3 (Nasal)		01/31/2025	Astra Zeneca	$43.00	90660		IN		
	In-Home Medicare Admin				$45.00	90480				
	PCV-20 Pneumococcal Conjugate		05/12/2023	Pfizer	$300.50	Z23 90677		LA RA		
	In-Home Medicare Admin									
	RSV					Z23				
	Arexvy		01/31/2025	GSK	$330.50	90679		LA RA		

Administration fee $50.50
COVID Administration fee $85.50 **Nurse's Signature** _____ **Date**_____