Paid

Clinic

LAKE REGION DISTRICT HEALTH UNIT
VACCINE ADMINISTRATION RECORD

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

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 Name (Last, First, Middle Initial):		Date of Birth:	Age:	Gender: ☐ Male ☐ Female
Address (Street or PO Box):	City:	County:	State:	Zip Code:
Primary Phone #	Daytime Phone #	Race:	Ethnicity: ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Unknown	
Birthplace: State or Country	Mother's Information (Last, First, Middle and Maiden Names):			
Name of Parent/Legal Guardian :	e-mail address ☐ (check box if appointment reminder wanted)			

VFC Eligibility Status - Check all that apply. ☐ Medicaid Eligible – If you have **any other insurance** please complete the Policy Holder Information in section below. **Medicaid Number**_____

☐ Native American ☐ No Insurance

☐ Underinsured (Vaccines **not covered** by health insurance) ☐ Insured -Vaccines **covered** by health insurance

Please complete Primary Insurance section below.

PRIMARY POLICY HOLDER INFORMATION

***Last Name:**_____ First Name_____ Middle Initial_____

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

Insurance Company Name and Address:_____

_____

(City) (State) (Zip)

***Policy Number:**_____ Group Number if Applicable:_____

Do you have a secondary insurance policy? Yes ☐ No ☐ **Medicare Number:** _____

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I acknowledge that I may request a copy of the Local Public 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 the Local Public 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 the Local Public Health Unit of all benefits payable for the Client's care.

X_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PERSON **DATE**

HEALTH UNIT USE ONLY

Tobacco Use: TOB ☐ SHS ☐ None ☐ **Advised:** Y ☐ N ☐ **Referred:** Y ☐ N ☐

Immunizations given: _____

Date if different then signed consent: _____

VACCINE ADMINISTRATION RECORD Admin. fee $45.50 unless listed

Health Screening Reviewed /Approved: Yes___ No___					*				
✓	**Vaccine(s) /VIS To Be Given**	**Codes**	**Vaccine Fee**	**VIS Date**	**Mfr. circle**	**Lot Number**	**Rte**	**Admin Site circle**	**Nurse Initials**
	DTaP (diphtheria-tetanus-pertussis)	Z23 90700	45.50	8/6/21	AVP GSK		IM	LA RA LT RT	
	DTaP/HepB/ IPV **(Pediarix)**	Z23 90723	115.50	10/15/21	GSK		IM	LA RA LT RT	
	DTaP / IPV **(Kinrix)**	Z23 90696	85.50	8/6/21 8/6/21	GSK		IM	LA RA LT RT	
	Haemophilus influenzae B **(Act-Hib)**	Z23 90648	35.50	8/6/21	AVP MSD		IM	LA RA LT RT	
	Haemophilus influenzae B **(Pedvax Hib)**	Z23 90647	45.50	8/6/21	AVP MSD		IM	LA RA LT RT	
	Hep A (Hepatitis A) 12 mo thru 18 YO	Z23 90633	60.50	10/15/21	MSD GSK		IM	LA RA LT RT	
	Hep A (Hepatitis A) Age 19 & Older	Z23 90632	95.50	10/15/21	MSD GSK		IM	LA RA LT RT	
	Hep B (Hepatitis B) Birth thru 19 YO	Z23 90744	45.50	5/12/23	GSK MSD		IM	LA RA LT RT	
	Hep B (Hepatitis B) Age 20 & Older	Z23 90746	85.50	5/12/23	GSK MSD		IM	LA RA LT RT	
	HPV-9	Z23 90651	300.50	8/6/21	MSD		IM	LA RA LT RT	
	Quadrivalent IIV4 (Admin 45.50) Age 6m thru Adult	Z23 90688 90686	35.50	8/6/21	AVP GSK		IM	LA RA LT RT	
	Influenza Nasal (Flumist) (Admin-32.00)	Influenza Nasal (Flumist)	38.00	8/6/21	Medimmune		IN	IN	
	Influenza High-Dose 65 and older (Admin 45.50)	Z23 90662	68.50	8/6/21	AVP		IM	LA RA	
	IPV	Z23 90713	55.50	8/6/21	AVP		IM/SQ	LA RA LT RT	
	MenQuadfi (Groups A, C, Y, W) (Meningococcal Conjugate)	Z23 90619	180.50	8/6/21	Sanofi		IM	LA RA LT RT	
	MenB Bexsero RP W/OMV IM	Z23 90620	240.50	8/6/21	GSK		IM	LA RA	
	MMR (Measles-Mumps-Rubella)	Z23 90707	115.50	8/6/21	MSD		SQ	LA RA LT RT	
	MMRV MMR/Varicella **(ProQuad)**	Z23 90710	305.50	8/6/21	MSD		SQ	LA RA LT RT	
	MCV-4(Meningococcal Conjugate)	Z23 90734	170.50	8/6/21	AVP		IM	LA RA LT RT	
	PCV-13 (Pneumococcal Conjugate)	Z23 90670	260.50	5/12/23	Pfizer		IM	LA RA LT RT	
	PCV-20 (Pneumococcal Conjugate)	Z23 90677	280.50	5/12/23	Pfizer		IM	LA RA LT RT	
	PPV23 (pneumococcal Polysaccharide)	Z23 90732	140.50	10/30/19	MSD		IM/SQ	LA RA LT RT	
	Rotavirus Rotarix	Z23 90681	160.50	10/15/21	GSK		PO	PO	
	Tdap (tetanus-diphtheria-pertussis)	Z23 90715	70.50	8/6/21	AVP GSK		IM	LA RA LT RT	
	Varicella (chickenpox)	Z23 90716	185.50	8/6/21	MSD		SQ	LA RA LT RT	
	Zoster- Zostavax Zoster - Shingrix	Z23 90736 90750	240.50 220.50	2/4/22	MSD GSK		SQ	LA RA	

1. Route: IM = Intramuscular, SQ = Subcutaneous, IN = Intransasal, PO = Oral ID= Intradermal
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_____

Nurse Signature _____ _____

7/01/2023 Date Vaccine Administered/VIS