Paid	**LAKE REGION DISTRICT HEALTH UNIT** **VACCINE ADMINISTRATION RECORD** 330 C Ave S/PO Box 86, Minnewaukan, ND 58351	Clinic Identification Number 04	___ THOR ___ NN

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:	State:	Zip Code:	County:
Primary Phone #	Daytime Phone #	Race:	Ethnicity: ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Unknown	
Birthplace: State or Country	Name of Parent/Legal Guardian :	Mother's Information (Last, First, Middle and Maiden Name):		

VFC Eligibility Status - Check <u>all</u> that apply. ☐ No Insurance ☐ Native American ☐ **Medicaid Number**_____
☐ Underinsured (Vaccines **not covered** by health insurance) ☐ **Medicare Number**_____
☐ Insured -Vaccines **covered** by health insurance – **please complete the Policy Holder Information in section below.**

<u>PRIMARY POLICY HOLDER INFORMATION</u>

Last Name:_____ First Name_____ Middle Initial_____

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

Insurance Company Name and Address:_____

*__Policy Number:__**_____ Group Number if Applicable:_____

Do you have a secondary insurance policy? Yes ☐ No ☐

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**

*****Limited Flu mist available upon request of Parent/Legal Guardian*****

VACCINE ADMINISTRATION RECORD

Health Screening Reviewed /Approved: Yes___ No____					Admin. fee $40.50 unless listed				
✓	**Vaccine(s) /VIS To Be Given**	**Codes**	**Vaccine Fee**	**VIS Date**	**Mfr.**	**Lot Number**	**Rte**	**Admin Site**	**Nurse Initials**
	Quadrivalent IIV4 – 6mo thru Adult	Z23 90685/6 - PFS 90687/8-MDV	35.50	08/15/19	AVP GSK		IM	LA RA LT RT	
	Influenza Nasal (Flumist) (Admin 32.00)	Z23 90672, 90473	38.00	08/15/19	MedImmune				
	Influenza High - Dose 65 and older	Z23 90662	68.50	08/15/19	AVP		IM	LA RA LT RT	

Nurse Signature _____ _____
Date Vaccine Administered/VIS

08/28/20