



BISMARCK-BURLEIGH PUBLIC HEALTH FLU VACCINE ADMINISTRATION RECORD



Public Health
Prevent. Promote. Protect.

Bismarck-Burleigh Public Health

Last Name	First Name	M.I.	Client's Date of Birth	Age
Mother's Name (if under 18)	Father's Name (if under 18)	Client's Birth State	Maiden Name/Nickname	
Street Address	City	State	Zip Code	Primary Physician
Home Phone	Work Phone	Cell Phone	Clinic Name	
Emergency Contact Name	Relationship	Phone Number	Allergies	

Please list all current medications.

Gender:	Ethnicity:	Race:	Preferred Language:	
Male	Hispanic	American Indian/Alaskan Native	Asian	English
Female	Not Hispanic	Black/African American	White	Spanish
		Native Hawaiian/Other Pacific Islander	Other	Other

Please check one of the following:	Tobacco Use:	Secondhand Smoke:	Do you have health insurance?
Bismarck City Resident	Current User	Exposed	Yes
Burleigh County Resident	Non User	Not exposed	No
Other County Resident			

If you answered no, do you need assistance with paying for services today? Yes No

Primary Insurance Provider:	Secondary Insurance (if applicable):
BCBS of ND	BCBS of ND
Medicaid	Medicaid
Medicare	Medicare
Medica	Medica
Sanford	Sanford
Sanford Medicaid Expansion	Sanford Medicaid Expansion
Other (Please List)	Other (Please List)

Primary Insurance Policy Number: **Secondary Insurance Policy Number (if applicable):**

Primary Insurance Policy Holder Name: **Secondary Insurance Policy Holder Name (if applicable):**

Policy Holder Date of Birth:	Relationship to Patient:	Policy Holder Date of Birth:	Relationship to Patient:
	Self Parent		Self Parent
	Spouse Other		Spouse Other

I acknowledge that I have been provided with BBPH'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 a direct payment to BBPH for all benefits that I am eligible for.

BBPH participates in the ND Health Information Network. You have the right to opt out of participation in the NDHIN. If you would like to "Opt Out" please request a form for completion.

For Clients Receiving Immunizations: 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 23-0-05.3. A copy of the appropriate Centers for Disease Control & Prevention Vaccine Information Statement(s) has been provided and can be accessed at <http://www.cdc.gov/vaccines/hcp/vis/>. 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 Patient/Parent or Legal Guardian (if under 18)

Date

FOR INTERNAL USE ONLY: ___ CR Entered ___ CR Scanned ___ VAR Scanned ___ Vaccine in CHAMP/THOR ___ THOR/Vaccine Verified ___ Supplies Entered ___ Billed ___ Pmt Posted

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CLIENT NAME: _____

CLIENT DATE OF BIRTH: _____

Please Check Appropriate Box		YES	NO
1.	Do you have a fever OR are you ill today?		
2.	Have you had a serious reaction to a previous dose of influenza vaccine?		
3.	Have you had a serious allergic reaction to eggs requiring emergency care?		
4.	Do you have a history of "Guillain-Barre" Syndrome?		
5.	Is this the first time you have received an influenza vaccination?		
6.	Have you had a pneumonia vaccination in the past?		

VFC - Vaccines for Children Eligibility Status (Check all that apply):

Date of Vaccination _____

FOR CLINIC USE ONLY

Medicaid No Insurance Native American Underinsured Insured

Vaccine(s) to be given	VIS Date	Manufacture	Lot Number	Dosage	Admin Site	Nurse's Signature
Influenza	08/7/15			0.25 ml 0.5 ml	LA RA LT RT	
PCV-13	11/5/2015	W/P		0.5 ml	LA RA LT RT	
PPV23-Pneumococcal	10/06/09	MSD		0.5 ml	LA RA LT RT	
High Dose Influenza	08/7/15	Sanofi		0.5 ml	LA RA	
Intradermal Flu Vaccine	08/7/15	Sanofi		0.1 ml	LA RA	

(Updated 7.22.16)