BISMARCK-BURLEIGH PUBLIC HEALTH
CLIENT RECORD/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:
☐ Male
☐ Female

Ethnicity:
☐ Hispanic
☐ Not Hispanic

Race:
☐ American Indian/Alaskan Native
☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander
☐ Asian
☐ White
☐ Other

Preferred Language:
☐ English
☐ Spanish
☐ Other

Please check one of the following:
☐ Bismarck City Resident
☐ Burleigh County Resident
☐ Other County Resident

Tobacco Use:
☐ Current User
☐ Non User

Secondhand Smoke:
☐ Exposed
☐ Not exposed

Do you have health insurance?
☐ Yes
☐ No

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

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

Secondary Insurance (if applicable):
☐ BCBS of ND
☐ Medicaid
☐ Medicare
☐ Medica
☐ Sanford
☐ Sanford Medicaid Expansion
☐ 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:
☐ Self ☐ Parent
☐ Spouse ☐ Other

Policy Holder Date of Birth:

Relationship to Patient:
☐ Self ☐ Parent
☐ 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 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.

How Did You Hear About Us?

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

FOR PUBLIC HEALTH STAFF USE ONLY

Client Name: Client Date of Birth: Date Vaccine Administered:

VFC-Vaccine For Children Eligibility Status(Check all that apply):
Medicaid No Insurance Native American Under Insured Insured

R/D (1)	Vaccine Source (2)	VACCINES TO BE GIVEN	VIS DATE	MFG (3)	LOT#	ROUTE (4)	ADMIN SITE (CIRCLE) (5)	NURSE SIGNATURE
		DTaP (Diphtheria–Tetanus-Pertussis)	8/24/18	GSK		IM	LA RA LT RT	
		DTaP/Hep B/IPV (Pediarix)	8/24/18 10/12/18 7/20/16	GSK		IM	LA RA LT RT	
		DTaP/IPV (Kinrix)	8/24/18 7/20/16	GSK		IM	LA RA LT RT	
		Hepatitis A	7/20/16	GSK MSD		IM	LA RA LT RT	
		Hepatitis A/Hepatitis B (Twinrix)	7/20/16 10/12/18	GSK		IM	LA RA LT RT	
		DTaP/Hib/IPV (Pentacel)	8/24/18 4/02/15 7/20/16	AVP		IM	LA RA LT RT	
		Hepatitis B	10/12/18	GSK MSD		IM	LA RA LT RT	
		Hib (Haemophilus Influenza B)	4/02/15	AVP MSD		IM	LA RA LT RT	
		HPV-9 (Human Papillomavirus)	12/2/16	MSD		IM	LA RA LT RT	
		Influenza	8/7/15			IM/IN	LA RA LT RT	
		IPV (Inactivated Polio Vaccine)	7/20/16	AVP		IM/SQ	LA RA LT RT	
		MCV-4 (Meningococcal Conjugate)	8/24/18	GSK AVP		IM	LA RA LT RT	
		Men B (Meningococcal) Bexsero Trumenba	8/9/16	GSK		IM	LA RA LT RT	
		MMR (Measles-Mumps-Rubella)	2/12/18	MSD		SQ	LA RA LT RT	
		MMRV (Measles-Mumps-Rubella-Varicella)	2/12/18	MSD		SQ	LA RA LT RT	
		PCV 13 (Pneumococcal Conjugate)	11/5/15	W/P		IM	LA RA LT RT	
		PPSV 23 (Pneumococcal Polysaccharide)	4/24/15	MSD		IM/SQ	LA RA LT RT	
		Rotavirus	2/23/18	MSD		PO	LA RA LT RT	
		Td (Tetanus-Diphtheria)	4/11/17	AVP MBL		IM	LA RA LT RT	
		Tdap (Tetanus-Diphtheria-Pertussis)	2/24/15	AVP GSK		IM	LA RA LT RT	
		Typhoid	5/29/12	AVP		IM	LA RA LT RT	
		Varicella (Chickenpox)	2/12/18	MSD		SQ	LA RA LT RT	
		Shingrix (Zoster)	2/12/18	GSK		IM	LA RA LT RT	
							LA RA LT RT	

1. **R/D:** **R** = Recommended Vaccines **D** = Vaccine Declined by Patient or Responsible Person
2. **VACCINE SOURCE (Fund):** **VFC** = VFC Eligible **P** = Privately Purchased
3. **MFG (Manufacturer):** **AVP** = Sanofi Pasteur (Aventis) **GSK** = GlaxoSmithKline **MBL** = Massachusetts Biological Laboratories **MSD** = Merck & Co. **W/P** = Wyeth **MEDI** = Medimmune **NOV** = Novartis
4. **ROUTE GIVEN:** **IM** = Intramuscular **SQ** = Subcutaneous **IN** = Intranasal **PO** = Oral **ID** = Intradermal
5. **ADMINISTRATION SITE:** **LA** = Left Arm **RA** = Right Arm **LT** = Left Thigh **RT** = Right Thigh

(Updated 11/1/18)