# 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
- ☐ Other _____

**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.

Signature of Patient/Parent or Legal Guardian (if under 18) | Date | How Did You Hear About Us?

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<br>8/15/19<br>7/20/16 | GSK | | IM | LA RA LT RT | |
| | | **DTaP/IPV** (Kinrix) | 8/24/18<br>7/20/16 | GSK | | IM | LA RA LT RT | |
| | | **Hepatitis A** | 7/20/16 | GSK<br>MSD | | IM | LA RA LT RT | |
| | | **Hepatitis A/Hepatitis B** (Twinrix) | 7/20/16<br>8/15/19 | GSK | | IM | LA RA LT RT | |
| | | **DTaP/Hib/IPV** (Pentacel) | 8/24/18<br>4/02/15<br>7/20/16 | AVP | | IM | LA RA LT RT | |
| | | **Hepatitis B** | 8/15/19 | GSK<br>MSD<br>DYN | | IM | LA RA LT RT | |
| | | **Hib** (Haemophilus Influenza B) | 4/02/15 | AVP<br>MSD | | IM | LA RA LT RT | |
| | | **HPV-9** (Human Papillomavirus) | 12/2/16 | MSD | | IM | LA RA LT RT | |
| | | **Influenza** | 8/15/19 | | | IM/IN | LA RA LT RT | |
| | | **IPV** (Inactivated Polio Vaccine) | 7/20/16 | AVP | | IM/SQ | LA RA LT RT | |
| | | **MCV-4** (Meningococcal Conjugate) | 8/15/19 | GSK<br>AVP | | IM | LA RA LT RT | |
| | | **Men B** Bexsero<br>(Meningococcal) Trumenba | 8/15/19 | GSK<br>PFZ | | IM | LA RA LT RT | |
| | | **MMR** (Measles-Mumps-Rubella) | 8/15/19 | MSD | | SQ | LA RA LT RT | |
| | | **MMRV** (Measles-Mumps-Rubella-Varicella) | 8/15/19 | MSD | | SQ | LA RA LT RT | |
| | | **PCV 13** (Pneumococcal Conjugate) | 11/5/15 | PFZ | | 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 | | IM | LA RA LT RT | |
| | | **Tdap** (Tetanus-Diphtheria-Pertussis) | 2/24/15 | AVP<br>GSK | | IM | LA RA LT RT | |
| | | **Typhoid** | 5/29/12 | AVP | | IM | LA RA LT RT | |
| | | **Varicella** (Chickenpox) | 8/15/19 | 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 **DYN** = Dynavax **MSD** = Merck & Co. **PFZ** = Pfizer **MEDI** = Medimmune
4. **ROUTE GIVEN:** **IM** = Intramuscular **SQ** = Subcutaneous **IN** = Intranasal **PO** = Oral
5. **ADMINISTRATION SITE:** **LA** = Left Arm **RA** = Right Arm **LT** = Left Thigh **RT** = Right Thigh

*(Updated 8/26/19)*