Emmons County Public Health will be coming to the school offering Influenza immunizations as well as Meningitis, Hepatitis A and HPV vaccinations on October 10, 2018. The nurses will be at the school from 1-4:30 pm. You can find the forms for both the flu as well as the regular immunization form for all other vaccinations to be filled out on the school's website. Parents are not required but encouraged to accompany grade school aged children. If you plan to have your child receive any other vaccination than the flu, please complete the regular form and have child return to the school secretary by October 8th so we can ensure an adequate supply of vaccine. Please have a copy of your insurance card attached to the form or completely fill out the insurance portion of the form. Any questions, please feel free to contact the Public Health Office at 254-4027.

INFORMATION ABOUT THE PERSON TO RECEIVE THE INFLUENZA VACCINE

First Name:	Middle Name:	Last Name	Date of Birth

Street Address	PO Box	City/State/Zip Code:	County:

Race:	GENDER:	State or Country you were born in
	_____ MALE _____ FEMALE	

Home Phone #	Cell Phone #	Maiden Name (If Applicable)

Questions must be asked prior to immunization administration:

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?			
2. Does the person to be vaccinated have an allergy to a component of the vaccine			
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?			
4. Has the person to be vaccinated ever had Guillain-Barre Syndrome?			

Tobacco Use (Check one)		**Current**		**Former**		**Never**
Second Hand Smoke Exposure		**Home**		**Work**		**None**

	W. Fax Referred to Quitline		**X. Quitline/Quitnet info given**		**Y. SHS info given**		**Z. No action taken**

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

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. 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 be given to the person names 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 no 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 for all benefits payable for the Client's care. *I authorize the release of any medical or other information necessary to process this claim.*

Signature of person to receive vaccine or person authorized to make the request:	Date
X	

FOR OFFICE USE ONLY:

Primary Insurance Company Name	**Policy Holder's Name**	**Policy Holder's Date of Birth**

Policy Number or Medicare-Medicaid #	**Group Number**	**Relationship to Client**

	Injection Site	Lot Number	Clinic Site	
Influenza	LA RA			
RN Signature:			Date Injection Given:	

VACCINE ADMINISTRATION RECORD
Emmons County Public Health

Clinic Identification Number:	49

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.
(Revised: 01/29/2018)

First Name	Middle Name	Last Name	Date of Birth

Street Address	PO Box	City	State	Zip Code

County	Mother's Maiden Name	Cell Phone Number	Home Phone Number

Race	Gender	State Born In

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS
(Please read and initial each)

_____ (initial) I acknowledge that I have been provided with Emmons County Public Health's Notice of Privacy Practices. I understand I may request an additional copy of the Notice at future contacts with Emmons County Public Health.

_____ (initial) I authorize the release of any medical or other information necessary to process this claim.

_____ (initial) I authorize the release of immunization records to the child's Daycare or School.

_____ (initial) 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).

_____ (initial) 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 Emmons County Public Health'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 Emmons County Public Health of all benefits payable for the Client's care.

THESE QUESTIONS ARE TO BE ANSWERED BY THE PERSON RECEIVING THE VACCINE OR PARENT/GUARDIAN MAKING THE REQUEST.
Questions 1-6 are used to determine if children 18 years of age or younger qualifies for the federally funded immunization program titled Vaccine for Children (VFC).

☐Yes ☐No ☐Unknown **1.** Is your child enrolled in Medicaid? **Medicaid Number**_____
Is Medicaid: ☐Primary Insurance ☐Secondary Insurance
☐Yes ☐No ☐Unknown **2.** Does your child have private health insurance?
☐Yes ☐No ☐Unknown **3.** Does your child's private health insurance cover vaccinations?
☐Yes ☐No ☐Unknown **4.** Is your child Native American or Alaskan Native?

HAS OR DOES THE PERSON RECEIVING THE VACCINE:

☐Yes ☐No ☐Unknown **5.** had any problems after receiving previous vaccines?
☐Yes ☐No ☐Unknown **6.** have any allergies to food, medicine, or any vaccine?
☐Yes ☐No ☐Unknown **7.** have a brain problem or ever had a seizure?
☐Yes ☐No ☐Unknown **8.** have any problems with his/her immune system, such as cancer, Leukemia, or HIV/AIDS?
☐Yes ☐No ☐Unknown **9.** taken cortisone, prednisone, other steroids, or anti-cancer drugs, or x-ray treatments in the past 3 months?
☐Yes ☐No ☐Unknown **10.** received any blood products or Immune Globulin in the past year?
☐Yes ☐No ☐Unknown **11.** had chickenpox? If yes, date of disease_____
☐Yes ☐No ☐Unknown **12.** received any vaccines in the past four weeks?
☐Yes ☐No ☐Unknown **13.** Is the person who is receiving the vaccine pregnant?
☐Yes ☐No ☐Unknown **14.** Is the person receiving the vaccine sick today?
☐Yes ☐No **15. Have you read the important Information Statement about the vaccine you or your child will be receiving?**

Tobacco Use: (Circle one)
Current Former Never

Second Hand Smoke Exposure:
Home Work None

W. Fax Referred to Quitline
X. Quitline/Quitnet info given
Y. SHS info given
Z. No action taken

_____ I have received HPV Vaccine information, but am refusing vaccination at this time.

X_____
SIGNATURE OF CLIENT OR RESPONSIBLE PERSON

_____
DATE

			AM PM
Patient	**Date of Birth**	**Date Injection Given**	**Time Injection Given**

☐ Copy of Card	Primary Insurance Company Name:	Policy Number:	Group Number:
	Policy Holders Name	**Policy Holder's Birthdate:**	*Relationship to Client*

	Vaccine(s) To Be Given	Codes	Cost of Vaccine	VIS Date	Lot Number	Rte	Admin Site circle	Nurse Signature
	DTaP (diphtheria-tetanus-Pertussis)	Z23 90700	36.00	05/17/07		IM	LA RA LT RT	
	DTaP/Hib/IPV (Pentacel)	Z23 90698	95.00	05/17/07 04/02/15 07/20/16		IM	LA RA LT RT	
	DTaP/IPV (Kinrix)	Z23 90696	54.00	05/17/07 07/20/16		IM	LA RA LT RT	
	Haemophilus influenzae B **(Pedvax Hib)** PRP-OMP	Z23 90647	25.00	04/02/15 3 doses		IM	LA RA LT RT	
	Hep A (Hepatitis A) 12 mo thru 18 YO	Z23 90633	32.00	07/20/16		IM	LA RA LT RT	
	Hep B (Hepatitis B) Birth thru 19 YO	Z23 90744	30.00	07//20/16		IM	LA RA LT RT	
	HPV-9 (Human Papillomavirus)	Z23 90651	192.00	12/02/16		IM	LA RA LT RT	
	MMR	Z23 90707	68.00	02/12/18		SQ	LA RA LT RT	
	MMRV	Z23 90710	194.00	02/12/18		SQ	LA RA LT RT	
	MCV-4 (Meningococcal Conjugate)	Z23 90734	122.00	03/31/16		IM	LA RA LT RT	
	PCV-13 (Pneumococcal Conjugate)	Z23 90670	182.00	11/05/15		IM	LA RA LT RT	
	Rotavirus (3 Dose)	Z23 90680	85.00	04/15/15		IM	LA RA LT RT	
	Td (tetanus-diphtheria)	Z23 90714	36.00	04/11/17		IM	LA RA LT RT	
	Tdap (tetanus-diphtheria-pertussis)	Z23 90715	36.00	02/24/15		IM	LA RA LT RT	
	Varicella (chickenpox)	Z23 90716	116.00	02/12/18		SQ	LA RA LT RT	
	Infuenza (split dose) Age 6 thru 35 mo.	Z23 90685	18.00	08/07/15		IM	LA RA LT RT	
	Influenza Age 3 thru Adult	Z23 90686	12.00	08/07/15		IM	LA A LT RT	
	DTaP/HepB/IPV (Pediarix)	Z23 90723	79.00	05/07/07 02/02/12 11/08/11		IM	LA RA LT RT	
	IPV	Z23 90713	33.00	07/20/16		IM SQ	LA RA LT RT	

1. Route: IM = Intramuscular, SQ = Subcutaneous, IN = Intranasal, PO = Oral
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_____

VFC/P: Indicates if state supplied or privately purchased. **VFC** = VFC eligible **P** = Privately purchased

90471 - Z23 – Admin of 1st Vaccine $29.00
90472 – Z23 – Admin Each Add'l Vaccine $16.00

NPI #: 1952511438
Medicaid #: 261QP0905X

EIN #: 450375236