Public Health
Prevent. Promote. Protect.

NELSON-GRIGGS DISTRICT HEALTH UNIT STUDENT VACCINE ADMINISTRATION RECORD

PO Box 365, McVille, ND 58254, Phone: (701) 322-5624, Fax: (701) 322-5111

Client's Name (Last, First, Middle Initial):	Date of Birth:	Age:	Grade:	School:	Male or Female

Address (Street or P.O. Box):	City:	State:	Zip Code:	County:

Parent's/Guardian's Name:	Home phone number:	Emergency phone number:

Please check all that apply regarding your child:

_____**American Indian or Alaskan Native**

_____**Has Medicaid – I.D. number:**_____

_____**Has NO medical insurance OR insurance does not cover immunizations.**

_____**Has medical insurance. Insurance company name:**_____

Policy number:_____

Group number (if applicable):_____

Name of Policy Holder:_____**Date of Birth:**_____

Address (if different than above):_____

_____

Relationship to person receiving immunization: _____

☐ I will not be present with my child during the Immunization Clinic at school.

☐ I wish to be present when my child is vaccinated. **(Arrangements must be made with parent & staff.)**

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I acknowledge that I have been provided with Nelson-Griggs District Health Unit's Notice of Privacy Practices. I understand I may request an additional copy of the Notice at future contacts with Nelson-Griggs District Health Unit.

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)

I authorize the release of any medical or other information necessary to process this claim. 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 Nelson-Griggs District 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 Nelson-Griggs District Health Unit of all benefits payable for the Client's care.

X_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

Please complete the following screening questions continuing on page 2.

Screening Questions – Complete entire section, no matter which vaccine your child is receiving.

	Please Initial Appropriate Box	YES	NO
1.	Is your child healthy today? (No fever or diarrhea)		
2.	Has your child had a serious allergic reaction to any vaccine?		
3.	Does your child have a history of seizures or seizure disorders?		
4.	Does your child use tobacco?		
5.	Is your child exposed to secondhand smoke in your home?		

Influenza Screening Questions – Complete entire section

	Please Initial Appropriate Box	YES	NO
6.	Has your child received a flu vaccination before?		
7.	Has your child had a serious reaction to a previous dose of influenza vaccine?		
8.	Has your child had a serious allergic reaction to eggs or to a component of the influenza vaccine?		
9.	Has your child ever had Guillain-Barre syndrome?		

*****If you would like the FluMist Vaccine, please complete the following questions.**

	Please Initial Appropriate Box	YES	NO
10.	Does the child to be vaccinated have a long-term problem with **asthma, lung disease, heart disease, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorders? ANY wheezing in the past year?**		
11.	Does the child to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as steroid, or cancer treatment with X-rays or drugs?		
12.	OLDER CHILDREN - Is your child pregnant?		
13.	Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and whom must be in a protective environment (such as in a hospital room with reverse air flow)?		
14.	Has your child received the **Chickenpox or Measles, Mumps, Rubella (MMR) immunizations in the past 30 days?**		
15.	Is your child receiving aspirin therapy for aspirin-containing therapy?		

If FluMist is unavailable, please initial to give permission for injectable vaccine. Initials _____

FOR CLINIC USE ON LY **Date of Vaccination: _____**

√	Vaccine(s) to be given	VIS Date	Manufacturer	Lot Number	Dosage	Admin Site	Nurse Signature
	Influenza	08/07/15	AVP		0.5 ml	LA RA	
	FluMist	08/07/15	MedImmune		0.1 ml per nostril	Nasal	