Public Health
Prevent. Promote. Protect.
Sargent County District Health

SARGENT COUNTY DISTRICT HEALTH UNIT
PO Box 237 | 316 Main Street
Forman, ND 58032
Office: (701) 724-3725 | Fax: (701) 724-3296

PRIVATE or VFC/VFA:
Location:

VACCINE ADMINISTRATION RECORD (VAR)

DEMOGRAPHIC INFO:

Client's Name (First, Middle Initial, Last):	**DOB:**	**Age:**
Address (Mailing: Street or P.O. Box):	**City:**	**State:**
Zip Code:	**Primary Phone Number:**	**Birth State | Country (if not in U.S):**
Race: Hawaiian or other Pacific Islander ____ White ____ African American or Black ____ Asian ____ American Indian or Alaska Native ____ Other Race ____	**Ethnicity:** Hispanic or Latino ____ Not Hispanic or Latino ____	**Gender Assigned at Birth:** Male _____ Female _____ Prefer Not to Answer ____
Mother's Name of Person Receiving Vaccine(s): (First, Maiden, Last)		
School Student Attends (circle): **Sargent Central** **Milnor Public School** **North Sargent**		**Grade Student In:**

INSURANCE INFO:

Name of Primary Insurance Company: **No Insurance: ____** **Medicare: ____** **Medicaid: ____** **Company Name: _____**		**Policy or ID Number:** _____
Name of Policy Holder (if other than self):	**DOB of Policy Holder:**	**Address of Policy Holder (if different than listed above):**

WHICH VACCINE ARE YOU CONSENTING FOR THE CLIENT TO RECEIVE?

□ **Influenza (injectable)**

□ **Influenza (nasal spray)** □ **Other: _____**

MY SIGNATURE BELOW INDICATES:

I acknowledge that I have been provided the Sargent County District Health Unit's (SCDHU) 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 SCDHU for all benefits that I am eligible for. SCDHU participates in the ND Health Information Network (NDHIN). 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 https://www.cdc.gov/vaccines/hcp/current-vis/index.html.

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: Person to receive vaccine or person authorized to sign on the client's behalf**:**	**Date:**
Printed name of individual signing above:	**Date:**

Please answer Screening Questions on following page: ⟹

SCREENING QUESTIONS – REFERRING TO PERSON RECEIVING THE VACCINE:

1. Is the person receiving the vaccine today sick? □ Yes □ No □ I don't know
2. Have allergies to medications, injectables, food, a vaccine component, or latex? □ Yes □ No □ I don't know
   Please list any allergies: _____
3. Had a serious reaction after receiving a previous vaccine? □ Yes □ No □ I don't know
4. Have a long-term health problem with heart disease, lung disease, asthma, kidney disease, liver disease, metabolic disease (e.g. diabetes), Guillain-Barré syndrome, solid organ transplant, no spleen, long term aspirin or salicylate medication, spinal fluid leak, anemia, or other blood disorder? □ Yes □ No □ I don't know
5. Have cancer, leukemia, HIV/AIDS, or any other immune system condition? □ Yes □ No □ I don't know
6. In the past 6 months, taken medications that affects the immune system such as prednisone, other steroids, anticancer drugs, drugs for treatment of rheumatoid arthritis, Crohn's disease, psoriasis, or had radiation treatments? □ Yes □ No □ I don't know
7. Had a seizure, brain, or other nervous system condition? □ Yes □ No □ I don't know
8. In the past year, received immunobiological treatments such as blood, blood products, immune (gamma) globulin, or an antiviral drug? □ Yes □ No □ I don't know
9. For Females – Pregnant or plan to become pregnant in the next month? □ Yes □ No □ I don't know
10. Received any vaccinations in the past 4 weeks? □ Yes □ No □ I don't know
    If so, please list: _____

CLINIC USE ONLY:

✓	Vaccine(s) To Be Administered	Route	VIS Date	MGF (Circle)	Lot Number	S/P	Admin Site	Vaccine Administrator
	Standard Dose (IIV3 P/F) (Fluzone®)	IM	01/31/2025	SP | GSK				
	High Dose (IIV3 P/F) (Fluzone®)	IM	01/31/2025	SP				
	Nasal Spray (LAIV) (FluMist®)	IN	01/31/2025	AZ				
Signature and Title of Person Administering Vaccine:						**Date Vaccine(s) Administered:**		

SCDHU Nurse: Verified immunization screening questions: _____ (initials)

SCDHU Nurse: Provided VIS(s) for each vaccine received: _____ (initials)

SCDHU Nurse: Verified insurance information: _____ (initials)

Comments regarding immunization screening questions:

Route: IM = Intramuscular, SQ = Subcutaneous, IN = Intranasal, PO = Oral
Manufacturer: SP = Sanofi Pasteur | GSK = GlaxoSmithKline | M = Merck & Co. | P = Pfizer | MOD = Moderna | AZ = Astrazeneca
Indicate if state-supplied or privately purchased: S = State-supplied, P = Privately purchased