3180 Center St NE

Salem, OR 97301

Vaccine Administration Record

Do you have insurance?
Yes__ No__

Patient Information

Last name:_____First Name:_____ Middle Initial:____

Date of birth:_____ Age_____ Gender: Male___ Female___ Other___

Address:_____City:_____ State:_____ Zip:_____

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

Telephone Number:_____ Ethnicity: Hispanic? Yes__ No__Primary Language:_____

Emergency Contact: Name_____**Phone** _____ **None**___

Patient Screening Questions	Yes	No	Don't know
1. Has the patient eaten in the past 4 hours?			
2. Does the patient have a fever or feel sick today?			
3. Does the patient have allergies to medicine, food, latex, or vaccines?			
4. Has the patient had a bad reaction to a vaccine in the past?			
5. Has the patient ever had a seizure or brain problem or have Guillain-Barre Syndrome?			
6. Does the patient have cancer, leukemia, HIV/AIDS, or other immune system problems?			
7. Does the patient have heart, lung, or kidney disease, diabetes, anemia, or other long term health problems?			
8. Has the patient taken prednisone, cortisone, other steroids, radiation or cancer treatment in the last 3 months?			
9. Has the patient received blood, blood products, or immune globulin (IG) in the past year?			
10. Is the patient pregnant or planning on becoming pregnant?			
11. Has the patient received vaccines in the past 4 weeks?			
12. Does the patient need a test for tuberculosis (TB) in the next month?			
13. Does the patient have asthma, smoke or use tobacco products, or live with someone who does?			
14. Does the patient have a shot card or record?			
15. Has the patient ever had chickenpox? If so, when? Date:_____			
16. Would you like information about local food banks and food pantries?			

Nurse's notes:

Marion County Health Department strongly recommends that all persons receiving vaccines wait 15 minutes for observation before leaving the clinic due to possible fainting, allergic reactions, and other potential injuries. By signing this form I acknowledge this recommendation. I have received the Vaccine Information Statement(s) for the vaccines to be given. I understand the benefits and risks of vaccination and have had all of my questions answered. I request that the vaccine be given to me or to the person named above, for whom I am responsible. I allow the release of any information needed to process insurance claims and request payments of medical benefits.

Print name:_____Signature:_____Date:_____

Must be parent or legal guardian for children under 15 years old

Please fill out this section if someone other than a parent or legal guardian will be bringing the patient in for their vaccines.

I give permission for _____ to allow my child to receive the following vaccines (circle all vaccines you want your child to receive): Hep B Hep A Dtap Tdap Polio Hib PCV13 Rotavirus MMR Varicella HPV Flu Meningococcal PPSV23

Special instructions for nurse:

OFFICE USE ONLY

Client name:_____ DOB:_____ Age:_____

VIS given? Yes___ No___ Explanation:_____

Code	Vaccine	Brand	Site	Dose	Lot #	Exp. Date	VIS Date
	DTaP Td Tdap ICD Code_____	Daptacel Infanrix Boostrix Tenivac	LAI RAI LTI RTI	0.5cc			
	DTaP/IPV/HBV	Pediarix	LAI RAI LTI RTI	0.5cc			
	DTaP/IPV/Hib	Pentacel	LAI RAI LTI RTI	0.5cc			
	DTaP/IPV	Kinrix	LAI RAI LTI RTI	0.5cc			
	Hib	Pedvax	LAI RAI LTI RTI	0.5cc			
	PCV13 PPSV23	Prevnar Pneumovax	LAI RAI LTI RTI	0.5cc			
	Rotavirus	Rotarix	Oral	1.0cc			
	Hep B	Engerix B Heplisav Recombivax Peds	LAI RAI LTI RTI	0.5cc 1.0cc			
	Hep A	Havrix	LAI RAI LTI RTI	0.5cc 1.0cc			
	IPV	IPOL	LAS RAS LTS RTS	0.5cc			
	MMR MMRV	MMR II Proquad	LAS RAS LTS RTS	0.5cc			
	Varicella	Varivax	LAS RAS LTS RTS	0.5cc			
	HPV	Gardasil 9	LAI RAI LTI RTI	0.5cc			
	Meningococcal	Menactra	LAI RAI LTI RTI	0.5cc			
	Hep A/B Combo	Twinrix	LAI RAI LTI RTI	1.0cc			
	Flu	Fluarix Flulaval Fluzone High Dose	LAI RAI LTI RTI	0.5cc			

Billing and Coding (Circle all that apply)

CHILDREN ONLY	ADULTS/KIDS w PRIVATE INSURANCE
M (OHP)	**O** (317 funds)
N (No insurance)	**B** (Private Insurance)
F (Underinsured)	**L** (Flu—Private)
A (Amer. Ind./AK)	**B** (Self-Pay)

RT #:_____

OHP #:_____

Staff:_____

Referrals:

- ☐ Tobacco Quit Line
- ☐ Reproductive Health
- ☐ STI
- ☐ OHP Sign-up
- ☐ Primary Care
- ☐ Other:_____

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Staff Signature:_____ RN Location:_____ Staff ID:_____ Date_____

Data Entry: Alert RainTree