

I acknowledged that the PCHD has provided me with their Notice of Privacy Practices.

Tobacco Use: ___ User ___ Non-User ___ Date ___
 Advised to quit? ___ Yes ___ No ___ N/A ___
 Cessation Referral Offered? ___ Yes ___ No ___ N/A ___
 Are you exposed to SHS? ___ Yes ___ No ___

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Information collected on this form will be used to document authorization for 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.

Patient's name: (Last, First, Middle)				Race: (Check box)	
Hispanic or Latino: (Circle) Yes No				<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White	
Date of birth:		Age:	Gender (Circle): Male Female		
Address: (Street or P.O. box)					
City:		State:	Zip code:	County:	Birth state or birth country (if not U.S.):
Primary telephone number:		Work telephone number:		E-mail address:	
Mother's name (if patient is 18 years or younger): Last, First, Middle				Mother's maiden name (if patient is 18 years or younger):	

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).

Signature – Person to receive vaccine or person authorized to sign on the patient's behalf: _____ **Date:** _____

VFC eligibility status: (Check all that apply) THIS SECTION MUST BE COMPLETED FOR ALL CHILDREN YOUNGER THAN 19.
 American Indian Medicaid-eligible No insurance Underinsured (vaccines not covered by health insurance)
 Not eligible (vaccines covered by health insurance) Other state eligible

✓	Vaccine(s) to be given	Route ¹	VIS date ²	Manufacturer ³	Lot number	S/P ⁴	Admin. site ⁵	Person admin. ⁶
	DTaP	IM		GSK SP				
	DTaP-HepB-IPV (Pediarix [®])	IM		GSK				
	DTaP-IPV/Hib (Pentacel [®])	IM		SP				
	DTaP-IPV (Kinrix [®])	IM		GSK				
	Hepatitis A	IM		GSK MSD				
	Hepatitis B	IM		GSK MSD				
	Hep A-Hep B (Twinrix [®])	IM		GSK				
	Hib (<i>H. influenzae</i> type B)	IM		GSK MSD SP				
	HPV	IM		GSK MSD				
	Influenza	ID/IM/IN						
	IPV	IM/SQ		SP				
	MMR	SQ		MSD				
	MMRV	SQ		MSD				
	Meningococcal Conjugate	IM		NOV SP				
	Pneumococcal Conjugate	IM		PFZ				
	Pneumococcal Polysaccharide	IM/SQ		MSD				
	Rotavirus	PO		GSK MSD				
	Td	IM		MBL SP				
	Tdap	IM		GSK SP				
	Shingles	SQ		MSD				
	Varicella	SQ		MSD				

Exemption or contraindication⁷: _____ **Date of exemption or contraindication:** _____

Signature and title of person administering vaccine: _____ **Date vaccine administered:** _____