

## 3180 Center St NE Salem OR 97301

Do you have ir	nsurance?
Yes	No

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 Hawaiia Telephone Number: Ethnicity: Hispanic? Yes No Primary Language:  Emergency Contact: Name Phone None  Patient Screening Questions Yes No kannel None  Patient Screening Questions Yes No be kently of 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 have allergies to medicine, food, latex, or vaccines?  5. Has the patient have allergies to medicine, food, latex, or vaccines?  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 received vaccines in the past 4 weeks?  11. Has the patient need a test for tuberculosis (TB) in the next month?  13. Does the patient have a shot card or record?	Salem, OR 97301	Vaccine Adi	ministration Re	cord	1	es	110
Date of birth:	DREGON alth & Human Services	Pat	ient Information	L			
Address:	Last name:	First Name:_			Mid	dle Init	ial:
Race: American Indian/Native Alaskan Asian African American White Pacific Islander/Native Hawaiia Telephone Number: Ethnicity: Hispanic? Yes NoPrimary Language:	Date of birth:	Age	Gender:	Male Female	Other		
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Phone None  Patient Screening Questions  Yes No Do King  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 need a test for tuberculosis (TB) in the next month?  13. Does the patient have ashma, 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?  16. Would you like information about local food banks and food pantries?  17. Does the patient bepartment strongly recommends that all persons receiving vaccines wait 15 minutes for observation before leading to the patient of the patient before leading that all persons receiving vaccines wait 15 minutes for observation before leading the patient of the patient before leading the patient of the patient before leading the patient of the patient before leading the patient patient before leading the patient before leading the patient patient before leading the patient patient patient patient leading the patient leading the patient lead the patient leading the patien	Race: American Indian/Native Alaska	n Asian	African American	White Pacific I	slander/Nat	ive Hav	waiian
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	se's notes:						
clinic due to possible fainting, allergic reactions, and other potential injuries. By signing this form I acknowledge this recommendat	rion County Health Department strongly rec	ommends that al	l persons receiving v	accines wait 15 minutes	for observat	ion befo	re leavii
e received the Vaccine Information Statement(s) for the vaccines to be given. I understand the benefits and risks of vaccination and ha							

16. Would you like informatio	n about local fo	od banks an	nd food	pantries	3?				
Nurse's notes:									
Marion County Health Department stro	ngly recommends t	hat all person	ns receivi	ng vaccin	es wait	15 minute	s for observa	tion befo	re leaving
the clinic due to possible fainting, allerg									
have received the Vaccine Information S			_						
had all of my questions answered. I requ		_		-			r whom I am	responsil	າle. I allow
the release of any information needed to	process insurance	claims and re	quest pay	ments of	medica	il benefits.			
Print name:	Sign	ature:					Date:		
Print name:		Must be p	parent or	legal gua	rdian fo	or children	under 15 year	ars old	
Please fill out this section if sem	oono othor than a	naront or loga	d guardia	مط النبير م	hringing	the nation	t in for their	vaccinos	
Please fill out this section if som	leone other than a	parent or lega	ii guaruia	ii wiii be	ninging	tile patien	it iii ior their	vaccines.	
I give permission for		to al	low my o	child to re	eceive tl	he followir	ng vaccines (	circle all	
vaccines you want your child to red								MMR	
Varicella HPV Flu Mo		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
	COVID	Moderna Johnson & Johnson Pfizer	LAI RAI	0.5cc			EU
	DTaP Td Tdap ICD Code	Infanrix Boostrix Tenivac	LAI RAI LTI RTI	0.5cc			08/06/21
	DTaP/IPV/HBV	Pediarix	LAI RAI LTI RTI	0.5cc			08/06/21 10/15/21
	DTaP/IPV/Hib	Pentacel	LAI RAI LTI RTI	0.5cc			08/06/21
	DTaP/IPV	Kinrix	LAI RAI LTI RTI	0.5cc			08/06/21
	Hib	Pedvax	LAI RAI LTI RTI	0.5cc			08/06/21
	PCV13 PPSV23	Prevnar Pneumovax	LAI RAI LTI RTI	0.5cc			08/06/21 10/30/19
	Rotavirus	Rotarix	Oral	1.0cc			10/15/21
	Нер В	Engerix B Recombivax Peds	LAI RAI LTI RTI	0.5cc 1.0cc			10/15/21
	Нер А	Havrix	LAI RAI LTI RTI	0.5cc 1.0cc			10/15/21
	IPV	IPOL	LAS RAS LTS RTS	0.5cc			08/06/21
	MMR MMRV	MMR II Proquad	LAS RAS LTS RTS	0.5cc			08/06/21
	Varicella	Varivax	LAS RAS LTS RTS	0.5cc			08/06/21
	HPV	Gardasil 9	LAI RAI LTI RTI	0.5cc			08/06/21
	Meningococcal	Menactra	LAI RAI LTI RTI	0.5cc			08/06/21
	Hep A/B Combo	Twinrix	LAI RAI LTI RTI	1.0cc			10/15/21
	Flu	Fluarix Flulaval Fluzone High Dose	LAI RAI LTI RTI	0.5cc			08/06/21

	Fluzone High Dose			
M (OHP)  N (No insurance)  F (Underinsured)	 S (Special)  RT #:  OHP #:  Staff:	 □ S □ C □ P □ F	: Tobacco Quit Line TI OHP Sign-up rimary Care ToodBox Other	

Staff Signature:	RN	Location:	Staff ID:	Date

Data Entry: Alert \_\_\_\_\_Raintree \_\_\_\_