Marion County
OREGON
Health & Human Services

Individual Vaccine Administration Record (VAR) Information

Individual's Name or label: _____ DOB: _____ Age: _____

Individual 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?	☐	☐	☐

***All persons who get vaccines need to wait 15 minutes before leaving the clinic. This is for your safety in case of fainting, allergic reaction, or side effects. By signing this I have read and understood this instruction:**

I received the Vaccine Information Statements for needed vaccines. I understand the benefits and risks of vaccination and had all my questions answered. I agree to get the requested vaccines for myself or the person/child I am responsible for. I allow the release of information needed for insurance claims or payments of medical benefits.

Print name: _____ Signature: _____ Date: _____

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

OFFICE USE ONLY

VIS given? ☐ Yes ☐ No Explanation: _____

Billing Code → Vaccine Admin Fee Code (1) 90471 (2+) 90472

CHILDREN ONLY

M (Medicaid, OHP) **F** (Underinsured, FQHC)
N (No Insurance) **A** (Am. Indian/AK Native)

ADULTS/KIDS w PRIVATE INSURANCE

O 317 funds (Other State Supplied) **L** Flu—Private (Locally Owned)
B Private Insurance or Self Pay (Billable/Not Eligible)
S Flu-Special (Special Projects)

Fund. Code	CVX	Vaccine	Brand	Site	Dose	Lot #	Exp. Date	VIS Date
	20 113 115	DTaP Td Tdap	Infanrix Tenivac Boostrix	LAI RAI LTI RTI	0.5 ml			08/06/21
	110	DTaP/HepB/IPV	Pediarix	LAI RAI LTI RTI	0.5 ml			10/15/21
	130	DTaP/IPV	Kinrix	LAI RAI LTI RTI	0.5 ml			08/06/21
	146	DTaP/IPV/Hib/HepB	Vaxelis	LAI RAI LTI RTI	0.5 ml			10/15/21
	120	DTaP/IPV/Hib	Pentacel	LAI RAI LTI RTI	0.5 ml			08/06/21
	83	Hep A (Pedi)	Havrix Pedi Vaqta Pedi	LAI RAI LTI RTI	0.5 ml			10/15/21
	52	Hep A (Adult)	Havrix	LAI RAI LTI RTI	1.0 ml			10/15/21
	08	Hep B (Pedi)	Engerix-B Recombivax HB	LAI RAI LTI RTI	0.5 ml			10/15/21
	43	Hep B (Adult 3 dose)	Engerix-B	LAI RAI LTI RTI	1.0 ml			10/15/21
	189	Hep B (Adult 2 dose)	Heplisav-B	LAI RAI LTI RTI	0.5 ml			10/15/21
	104	Hep A/B	Twinrix	LAI RAI LTI RTI	1.0 ml			10/15/21
	49	Hib	PedvaxHIB	LAI RAI LTI RTI	0.5 ml			08/06/21
	165	HPV9	Gardasil 9	LAI RAI LTI RTI	0.5 ml			08/06/21
	10	IPV Polio	IPOL	LAI RAI LTI RTI	0.5 ml			08/06/21
	203	Meningococcal ACWY	MenquadFi	LAI RAI LTI RTI	0.5 ml			08/06/21
	03 94	MMR MMRV	MMR II ProQuad	LAS RAS LTS RTS	0.5 ml			08/06/21
	133 33	PCV13 PPSV23	Prevnar 13 PneumoVax 23	LAI RAI LTI RTI	0.5 ml			02/04/22 10/30/19
	119	Rotavirus	Rotarix	Oral	1.0 ml			10/15/21
	21	Varicella	Varivax	LAS RAS LTS RTS	0.5 ml			08/06/21
	150	Flu	Flulaval (VFC) Fluarix (Local)	LAI RAI LTI RTI	0.5 ml			08/06/21

Staff ID: _____ Date: _____ ☐ Entered in DrCloud ☐ Uploaded to DrCloud

Marion County
OREGON
Health & Human Services

PRINT CLEARLY

Demographic Information Form

INDIVIDUAL DEMOGRAPHIC *required fields ☐ **Twin**

Legal Name ***First:** _____ **Middle:** _____ ***Last:** _____

Preferred (Lived) Name: _____ Pronouns: _____ ***DOB:** _____

***Legal Sex:** _____ Sex Assigned at Birth: _____ Gender Identity: _____

Marital Status: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Unknown

Guardian/Parent Name(s): _____

Ethnicity (for Reporting): _____ ☐ Not of Hispanic ☐ Unknown

Race (for Reporting): ☐ Alaska Native ☐ American Indian ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ Other Single Race ☐ Two or More Unspecified Races

SSN: _____ Salesforce #: _____ Medicare #: _____

Do you have Health Insurance: ☐ No ☐ OHP Can we bill your insurance? ☐ Yes ☐ No

☐ Private Insurance Name: _____ Medicaid/OHP/Prime #: _____

Residential Address →

***Address Line:** _____

***City:** _____ ***State:** _____ ***Zip Code:** _____ County: _____

Mailing Address (if different from above): _____

Primary #: _____ Type (Primary #): ☐ Home ☐ Mobile ☐ Other

Voice Messages: ☐ Detailed Message ☐ Call Back Only ☐ No Messages

Secondary #: _____ Type (Secondary #): ☐ Home ☐ Mobile ☐ Other

Contact Email: _____ Allows Email: ☐ Yes ☐ No

PREFERENCES

Language, Accessibility & Supports →

Preferred Verbal Language: _____ Interpreter Needed: ☐ Foreign ☐ Hearing ☐ None

Type of Interpreter: ☐ Spoken Language ☐ American Sign Language ☐ Other _____

Preferred Written Language: _____ Bilingual Clinician Preferred: ☐ Yes ☐ No

Reminder/Notifications → Individual needs to sign the Electronic Communication Policy form

Allow Voice Message: ☐ Yes ☐ No Allow SMS: ☐ Yes ☐ No

Allow Mail Message: ☐ Yes ☐ No Allow Email: ☐ Yes ☐ No

PRIMARY CONTACT In case of an emergency whom should we contact? ☐ **None/911**

Name: _____ Relationship: _____

Primary Phone #: _____ ☐ Home ☐ Work ☐ Cell ☐ Other

Primary Language: _____ Older than 18 years old? ☐ Yes ☐ No