Marion County
OREGON
Health Department

# Vaccine Administration Record

## 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:_____

| Patient Screening Questions | Yes | No | Don't know |
|---|---|---|---|
| 1. Does the patient have a fever or feel sick today? | | | |
| 2. Does the patient have allergies to medicine, food, latex, or vaccines? | | | |
| 3. Has the patient had a bad reaction to a vaccine in the past? | | | |
| 4. Has the patient ever had a seizure or brain problem or have Guillain-Barre Syndrome? | | | |
| 5. Does the patient have cancer, leukemia, HIV/AIDS, or other immune system problems? | | | |
| 6. Does the patient have heart, lung, or kidney disease, diabetes, anemia, or other long term health problems? | | | |
| 7. Has the patient taken prednisone, cortisone, other steroids, radiation or cancer treatment in the last 3 months? | | | |
| 8. Has the patient received blood, blood products, or immune globulin (IG) in the past year? | | | |
| 9. Is the patient pregnant or planning on becoming pregnant? | | | |
| 10. Has the patient received vaccines in the past 4 weeks? | | | |
| 11. Does the patient need a test for tuberculosis (TB) in the next month? | | | |
| 12. Does the patient have asthma, smoke, use tobacco products, or live with someone who does? | | | |
| 13. Does the patient have a shot card or record? | | | |
| 14. Has the patient ever had chickenpox? If so, when? Date:_____ | | | |
| 15. 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<br>Td<br>Tdap<br>ICD Code____ | Daptacel<br>Infanrix<br>Boostrix<br>Tenivac | LAI RAI<br><br>LTI RTI | 0.5cc | | | |
| | DTaP/IPV/HBV | Pediarix | LAI RAI<br>LTI RTI | 0.5cc | | | |
| | DTaP/IPV/Hib | Pentacel | LAI RAI<br>LTI RTI | 0.5cc | | | |
| | DTaP/IPV | Kinrix | LAI RAI<br>LTI RTI | 0.5cc | | | |
| | Hib | Pedvax | LAI RAI<br>LTI RTI | 0.5cc | | | |
| | PCV13<br>PPSV23 | Prevnar<br>Pneumovax | LAI RAI<br>LTI RTI | 0.5cc | | | |
| | Rotavirus | Rotarix | Oral | 1.0cc | | | |
| | Hep B | Engerix B | LAI RAI<br>LTI RTI | 0.5cc<br>1.0cc | | | |
| | Hep A | Havrix | LAI RAI<br>LTI RTI | 0.5cc<br>1.0cc | | | |
| | IPV | IPOL | LAS RAS<br>LTS RTS | 0.5cc | | | |
| | MMR<br>MMRV | MMR II<br>Proquad | LAS RAS<br>LTS RTS | 0.5cc | | | |
| | Varicella | Varivax | LAS RAS<br>LTS RTS | 0.5cc | | | |
| | HPV | Gardasil 9 | LAI RAI<br>LTI RTI | 0.5cc | | | |
| | Meningococcal | Menactra | LAI RAI<br>LTI RTI | 0.5cc | | | |
| | Meningococcal B | Bexsero | LAI RAI<br>LTI RTI | 0.5cc | | | |
| | Hep A/B Combo | Twinrix | LAI RAI<br>LTI RTI | 1.0cc | | | |
| | Flu | Fluzone<br>Fluarix | LAI RAI<br>LTI RTI | 0.25cc<br>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:_____

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

Data Entry: Alert_____ RainTree_____

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