

Cash \$

Credit \$

Davis County Health Department **VACCINE ADMINISTRATION RECORD**

Clearfield Clinic 22 South State Street Clearfield, UT 84015 801 - 525 - 5020

anguage Race White Alaskan Native Other Ethnicity Hispanic Non Hispanic Male Female	Clinic Location:			· · · · · · · · · · · · · · · · · · ·			Date	e:			
Alternate Phone Alternate Phone Parcific Islander Parcific	Last Name			First Name	Mi	ddle	Date of Birt	h (mm/dd/yy)	Patient Aç	<mark>je</mark>	
Alternate Phone # Alternate Phone # E-mail	Language		Asian	☐ American Indian	ther Eth		│]Non Hispani	c	'	□ Fer	male
rimary Health Insurance: Policy # Relationship to Patient: By signing this form, I understand that Davis County Health Department expects payment at the time of service unless other billing arrangements have been made. I understand that all charges incurred are my responsibility. If the Davis County Health Department has a contract with my insurance company, only services covered by my plan will be paid. It is my responsibility to know what my plan covers and agree to pay any portion not covered. I understand that file Davis County Health Department does not have a contract with my insurance company, only services covered by my plan will be paid. It is my responsibility to know what my plan covers and agree to pay any portion not covered. I understand that if the Davis County Health Department does not have a contract with my insurance company, and proposed incurred. Why signature indicates that I have reviewed and read a copy of the Notice of Privacy Practice (HIPAA), and have explained to me the Vaccine Information Statement (VIS) for each vaccine that I am requesting be given to the person named on this form. I further release the Davis county health department from liability regarding immunization services rendered. **RINT NAME** SIGNATURE** SIGNATURE* Sareening Questionnaire - Please complete for the person to be vaccinated Are you sick today? Or you have allegries to medications, food, vaccine components, or latex? Explain:	Address:	1			Cit	<mark>y</mark>		State	Zip Code		
By signing this form, I understand that Davis County Health Department expects payment at the time of service unless other billing arrangements have been made. I understand that all charges incurred are my responsibility. If the Davis County Health Department has a contract with my insurance company, only services covered by my plan will be paid. It is my responsibility to know what my plan covers and agree to pay any portion not covered. I understand that if the Davis County Health Department does not have a contract with my insurance company, only services covered by my plan will be paid. It is my responsibility to know what my plan covers and agree to pay any portion not covered. I understand that if the Davis County Health Department does not have a contract with my insurance propensible for all charges incurred. My signature includes that I have reviewed and read a copy of the Notice of Privacy Practice (HIPAA), and have explained to me the Vaccine Information Statement (VIS) for each vaccine that I am requesting be given to the person named on this form. I further release the Davis county health department from Italiability regarding immunization services rendered. **RINT NAME** **SIGNATURE** **SIGNATURE** **SIGNATURE** **SIGNATURE** **SIGNATURE** **SIGNATURE** **DATE** **Letationshipp** **Screening Questionnaire - Please complete for the person to be vaccinated **No** **Yes* **Are you a have allergies to medications, food, vaccine components, or latex? Explain:	Cell Phone #			Alternate Phone #	E-r	nail		1			
By signing this form, I understand that Davis County Health Department expects payment at the time of service unless other billing arrangements have beer made. I understand that all charges incurred are my responsibility. If the Davis County Health Department has a contract with my insurance company, only services covered by my plan will be paid. It is my responsibility to know what my plan covers and agree to pay any portion not covered. I understand that if the Davis County Health Department does not have a contract with my insurance company, I am responsible for all charges incurred. My signature indicates that I have reviewed and read a copy of the Notice of Privacy Practice (HIPAA), and have explained to me the Vaccine Information Statement (VS) for each vaccine that I am requesting be given to the person named on this form. I further release the Davis county health department from liability regarding immunization services rendered. **RINT NAME:** SIGNATURE:** SIGNATURE:** STATE:** Letelationship:** Screening Questionnaire - Please complete for the person to be vaccinated **Screening Questionnaire - Please complete for the person to be vaccinated Screening Questionnaire - Please complete for the person to be vaccinated **No** Screening Questionnaire - Please complete for the person to be vaccinated **No** Screening Questionnaire - Please complete for the person to be vaccinated Screening Questionnaire - Please complete for the person to be vaccinated **No** Screening Questionnaire - Please complete for the person to be vaccinated Screening Questionnaire - Please complete for the person to be vaccinated No** Ves Are you sick today? Do you have allergies to medications, food, vaccine components, or latex? Explain: Do you have long-term health problems with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., idiabetes), anemia, or other blood disorder? Explain: Do you have cancer, leukemia, AIDS, or any other immune system problem? or in the past 3 months, have	Primary Health Insurance:			Policy #	Ins	urance Policy Hold	er: (Exact Nam	e as listed on	Card)		
made i understand that all charges incurred are my responsibility. If the Davis County Health Department has a contract with my insurance company, noty services covered by my plan will be paid. It is my responsibility to know what my plan covers and agree to pay any portion not covered. I understand that if the Davis County Health Department does not have a contract with my insurance company, I am responsible for all charges incurred. Why signature indicates that I have reviewed and read a copy of the Notice of Privacy Practice (HIPAA), and have explained to me the Vaccine Information Statement (VIS) for each vaccine that I am requesting be given to the person named on this form. I further release the Davis county health department from liability regarding immunization services rendered. SIGNATURE: SOC pound to be vaccinated No Yes Veryou sick today? Do you have allergies to medications, food, vaccine components, or latex? Explain: Lave you had a serious reaction after receiving a vaccination? Explain: Do you have long-term health problems with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? Explain: Do you have cancer, leukemia, AIDS, or any other immune system problem? or in the past 3 months, have you taken medications that affect your immune system problem? Explain: Lave you had a seizure or brain or other nervous system problem? Explain Do you have cancer, leukemia, AIDS, or any other immune system problem? Explain Do you have cancer evelved a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral brug? Explain: Lave you had a seizure or brain or other nervous system problem? Explain Do you have cancer evelved a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral brug? Explain: Lave you received any vaccinations in the past 4 weeks?	Insurance Policy Holder Date	of Birth:		Relationship to Patient:	Ho	me Address of Poli	cy Holder if Di	fferent than Pa	atient:		
Screening Questionnaire - Please complete for the person to be vaccinated No Yes Are you sick today? Do you have allergies to medications, food, vaccine components, or latex? Explain: -lave you had a serious reaction after receiving a vaccination? Explain: Do you have long-term health problems with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? Explain: Do you have cancer, leukemia, AIDS, or any other immune system problem? or in the past 3 months, have you taken medications that affect your immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of heumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	made. I understand that all company, only services co covered. I understand that charges incurred. My signature indicates that Statement (VIS) for each var	I charges overed by if the Dav I have reviccine that	incurre my plai vis Cou iewed a I am rec	d are my responsibility. In will be paid. It is my res nty Health Department do nd read a copy of the Notic puesting be given to the pe	If the Davis sponsibility oes not hav	County Health Dep to know what my p e a contract with n Practice (HIPAA), a	artment has a plan covers a ny insurance and have expla	a contract with a contract with a company, I are the company in the contract to me the co	th my insurate ay any po m respons	rance rtion n sible fo	ot or all ation
Screening Questionnaire - Please complete for the person to be vaccinated No Yes Are you sick today? Do you have allergies to medications, food, vaccine components, or latex? Explain: Have you had a serious reaction after receiving a vaccination? Explain: Do you have long-term health problems with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? Explain: Do you have cancer, leukemia, AIDS, or any other immune system problem? or in the past 3 months, have you taken nedications that affect your immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of heumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? Have you had a seizure or brain or other nervous system problem? Explain During the past year, received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? Explain: Have you received any vaccinations in the past 4 weeks? Explain: Hermales): Are you pregnant or is there a chance you could become pregnant during the next month? —Additional Questions for COVID Vaccine — No Yes Have you received a dose of a COVID vaccine? If yes, which vaccine? Have you received monoclonal antibodies or convalescent plasma for COVID to prevent or treat COVID-19? Have you tested positive for COVID in the past 10 days? Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? Have you had a blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome?	PRINT NAME:			SIGNATURE	E:			DATE:			
Are you sick today? Do you have allergies to medications, food, vaccine components, or latex? Explain: Have you had a serious reaction after receiving a vaccination? Explain: Do you have long-term health problems with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? Explain: Do you have cancer, leukemia, AIDS, or any other immune system problem? or in the past 3 months, have you taken medications that affect your immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of heumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? Have you had a seizure or brain or other nervous system problem? Explain During the past year, received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral larug? Explain: Have you received any vaccinations in the past 4 weeks? Explain: Females): Are you pregnant or is there a chance you could become pregnant during the next month? —-Additional Questions for COVID Vaccine	Relationship: □ Self □ Pare	nt or Guar	dian					Staff Initia	ls:		
Do you have allergies to medications, food, vaccine components, or latex? Explain: Have you had a serious reaction after receiving a vaccination? Explain: Do you have long-term health problems with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? Explain: Do you have cancer, leukemia, AIDS, or any other immune system problem? or in the past 3 months, have you taken medications that affect your immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of heumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? Have you had a seizure or brain or other nervous system problem? Explain During the past year, received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? Explain: Have you received any vaccinations in the past 4 weeks? Explain: Females): Are you pregnant or is there a chance you could become pregnant during the next month? Have you received a dose of a COVID vaccine? If yes, which vaccine? Have you received monoclonal antibodies or convalescent plasma for COVID to prevent or treat COVID-19? Have you tested positive for COVID in the past 10 days? Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? Have you had a blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome?	Scree	<mark>ning Q</mark> ւ	<mark>lestio</mark>	nnaire - Please com	plete for t	he person to b	e vaccinat	ed		No	Yes
Have you had a serious reaction after receiving a vaccination? Explain: Do you have long-term health problems with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? Explain: Do you have cancer, leukemia, AIDS, or any other immune system problem? or in the past 3 months, have you taken medications that affect your immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of heumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? Have you had a seizure or brain or other nervous system problem? Explain During the past year, received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? Explain: Have you received any vaccinations in the past 4 weeks? Explain: Females): Are you pregnant or is there a chance you could become pregnant during the next month? —— Additional Questions for COVID Vaccine—— No Yes Have you received a dose of a COVID vaccine? If yes, which vaccine? Have you received monoclonal antibodies or convalescent plasma for COVID to prevent or treat COVID-19? Have you had a blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome?	Are you sick today?										
Do you have long-term health problems with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? Explain: Do you have cancer, leukemia, AIDS, or any other immune system problem? or in the past 3 months, have you taken medications that affect your immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of heumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? Have you had a seizure or brain or other nervous system problem? Explain During the past year, received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? Explain: Have you received any vaccinations in the past 4 weeks? Explain: Females): Are you pregnant or is there a chance you could become pregnant during the next month? ———————————————————————————————————	Do you have allergies to n	nedicatio	ns, foo	d, vaccine components,	or latex? E	xplain:					
diabetes), anemia, or other blood disorder? Explain: Do you have cancer, leukemia, AIDS, or any other immune system problem? or in the past 3 months, have you taken medications that affect your immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of heumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? Have you had a seizure or brain or other nervous system problem? Explain During the past year, received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? Explain: Have you received any vaccinations in the past 4 weeks? Explain: Females): Are you pregnant or is there a chance you could become pregnant during the next month? Additional Questions for COVID Vaccine No Yes Have you received a dose of a COVID vaccine? If yes, which vaccine? Have you received monoclonal antibodies or convalescent plasma for COVID to prevent or treat COVID-19? Have you tested positive for COVID in the past 10 days? Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? Have you had a blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome?	Have you had a serious re	eaction af	ter rec	eiving a vaccination? Ex	xplain:						
medications that affect your immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of heumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? Have you had a seizure or brain or other nervous system problem? Explain During the past year, received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? Explain: Have you received any vaccinations in the past 4 weeks? Explain: Females): Are you pregnant or is there a chance you could become pregnant during the next month? ——Additional Questions for COVID Vaccine—— No Yes Have you received a dose of a COVID vaccine? If yes, which vaccine? Have you received monoclonal antibodies or convalescent plasma for COVID to prevent or treat COVID-19? Have you tested positive for COVID in the past 10 days? Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? Have you had a blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome?					disease, as	thma, kidney dise	ase, metabo	lic disease (e	∋.g.,		
During the past year, received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? Explain: Have you received any vaccinations in the past 4 weeks? Explain: Females): Are you pregnant or is there a chance you could become pregnant during the next month? Additional Questions for COVID Vaccine No Yes Have you received a dose of a COVID vaccine? If yes, which vaccine? Have you received monoclonal antibodies or convalescent plasma for COVID to prevent or treat COVID-19? Have you tested positive for COVID in the past 10 days? Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? Have you had a blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome?	medications that affect you	ur immun	e syste	em such as prednisone,	other sterc	ids, or anticancer			tment of		
drug? Explain: Have you received any vaccinations in the past 4 weeks? Explain: Females): Are you pregnant or is there a chance you could become pregnant during the next month? Additional Questions for COVID Vaccine No Yes Have you received a dose of a COVID vaccine? If yes, which vaccine? Have you received monoclonal antibodies or convalescent plasma for COVID to prevent or treat COVID-19? Have you tested positive for COVID in the past 10 days? Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? Have you had a blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome?	Have you had a seizure o	r brain or	other r	nervous system problem	n? Explain						
Females): Are you pregnant or is there a chance you could become pregnant during the next month? Additional Questions for COVID Vaccine No Yes Have you received a dose of a COVID vaccine? If yes, which vaccine? Have you received monoclonal antibodies or convalescent plasma for COVID to prevent or treat COVID-19? Have you tested positive for COVID in the past 10 days? Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? Have you had a blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome?	During the past year, rece drug? Explain:	ived a tra	ınsfusio	on of blood or blood pro	ducts, or be	een given immune	e (gamma) gl	obulin or an	antiviral		
Additional Questions for COVID Vaccine Have you received a dose of a COVID vaccine? If yes, which vaccine? Have you received monoclonal antibodies or convalescent plasma for COVID to prevent or treat COVID-19? Have you tested positive for COVID in the past 10 days? Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? Have you had a blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome?	Have you received any va	ccination	s in the	e past 4 weeks? Explain	1:						
Have you received a dose of a COVID vaccine? If yes, which vaccine? Have you received monoclonal antibodies or convalescent plasma for COVID to prevent or treat COVID-19? Have you tested positive for COVID in the past 10 days? Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? Have you had a blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome?	(Females): Are you pregna	ant or is t	here a	chance you could beco	me pregna	nt during the next	month?				
Have you received monoclonal antibodies or convalescent plasma for COVID to prevent or treat COVID-19? Have you tested positive for COVID in the past 10 days? Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? Have you had a blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome?				Additional Questions	for COVID	Vaccine				No	Yes
Have you tested positive for COVID in the past 10 days? Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? Have you had a blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome?	Have you received a dose	of a CO	VID va	ccine? If yes, which vac	cine?						
Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? Have you had a blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome?	Have you received monoc	clonal ant	ibodies	or convalescent plasm	a for COVII	O to prevent or tre	at COVID-19	9?			
Have you had a blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome?	Have you tested positive f	or COVID) in the	past 10 days?							
Syndrome?	Do you have a health con	dition or a	are you	undergoing treatment t	that makes	you moderately o	r severely im	munocompr	omised?		
Do you have dermal fillers (cosmetic medical device implants)?	Have you had a blood dise Syndrome?	order, my	ocardit	is/pericarditis, heparin-i	induced thre	ombocytopenia or	Multisystem	Inflammator	У		
· , , , , , , , , , , , , , , , , , , ,	Do you have dermal fillers	(cosmet	ic med	ical device implants)?							

PAYMENT SECTION (FOR OFFICE USE ONLY)

Check # / \$

Ву

VFC Eligible □



Davis County Health Department VACCINE ADMINISTRATION RECORD

Clearfield Clinic 22 South State Street Clearfield, UT 84015 801 - 525 - 5020

TO BE COMPLETED BY THE VACCINE ADMINISTRATOR

VACCINE TYPE	CPT code	Manufacturer, Lote & Expiration Date	Vaccine	Administrat	Current VIS provided	
		•	Site	Route	Dose	Initials
FLUZONE HIGH DOSE 65+	90662		□RD □LD	IM	0.7 ml	
FLUBLOK HIGH DOSE 18+	90682		□RD □LD	IM	0.5 ml	
FLUZONE, FLULAVAL 6 MON+	90686		□RD □LD	IM	0.5 ml	
FLUARIX (AHB ONLY) 19+	QUAD4		□RD □LD	IM	0.5 ml	
FLUCELVAX 6 MON+	90674		□RD □LD	IM	0.5 ml	
FLUMIST 2-49 yrs	90672		Nostril	Intranasal	0.2 ml	
TDAP	90715		□RD □LD	IM	0.5 ml	
PNEUMONIA PPSV23	90332		□RD □LD	IM	0.5 ml	
PNEUMONIA PCV20	90677		□RD □LD	IM	0.5 ml	
ZOSTER (SHINGLES) (0,2-6 mon) 50yrs+	90750		□RD □LD	IM	0.5 ml	
RSV ABRYSVO	90678		□RD □LD	IM	0.5 ml	
RSV AREXVY	90679		□RD □LD	IM	0.5 ml	
OTHER			□RD □LD			
OTHER			□RD □LD			

VACCINE TYPE	CPT code	Manufacturer, Lote & Expiration Date	Vaccine Administration Date:			Current VIS provided	
1			Site	Route	Dose	Initials	
PFIZER			□RD □LD	IM			
MODERNA			□RD □LD	IM			
NOVAVAX			□RD □LD	IM	0.5 ml		

VACCINE TYPE	СРТ	Manufacturer, Lote & Expiration Date	Vaccine Administration Date:			Current VIS provided	
	code	P	Site	Route	Dose	Initials	
MCV4 (MENQUADFI)	90619		□RD □LD	IM	0.5 ml		
HPV9 (GARDASIL)	90651		□RD □LD	IM	0.5 ml		
DTAP, POLIO (KINRIX, QUADRACEL)	90696		□RD □LD	IM	0.5 ml		
MMR, VARICELLA (PROQUAD)	90710		□RA/VL □LA/VL	SQ	0.5 ml		

PAYMENT SECTION (FOR OFFICE USE ONLY)

Cash \$	Credit \$	Check #	/\$	VFC Eligible □	Ву