Davis County Health Department

# VACCINE ADMINISTRATION RECORD

**Clearfield Clinic**
22 South State St
Clearfield, UT 84015
**(801) 525-5020**

Clinic Location: _____ Date: _____

Fill Out the Highlighted Areas

| | | | | |
|---|---|---|---|---|
| **Client Last Name** | **First Name** | **Middle** | **Date of Birth (mm/dd/yy)** | **Patient Age** |
| **Language** | **Race:** ☐ White ☐ American Indian ☐ Pacific Islander ☐ Black ☐ Alaskan Native ☐ Asian | **Ethnicity** ☐ Hispanic ☐ Non Hispanic | | **Gender** ☐ Male ☐ Female |
| **Address:** | | **City** | **State** | **Zip Code** |
| **Phone #** | **Alternate Phone #** | **E-mail** | | |
| **Primary Health Insurance:** | **Policy# Tricare: benefit#or sponsor SS:** | **Insurance Policy Holder: (Exact Name as listed on Card)** | | |
| **Secondary Health Insurance:** | **Policy # Tricare Benefit #/ sponsor SSN:** | **Insurance Policy Holder: (Exact Name as listed on Card)** | | |
| **Insurance Policy Holder Date of Birth (mm/dd/yy):** | **Relationship to Patient:** | **Home Address of Policy Holder if Different than 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 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 (HIPPA) and have had 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.

Full Name: _____ SIGNATURE: _____ Date: _____

Relationship: ☐ **Self** ☐ **Parent or Guardian**

| **Screening Questionnaire - Please complete for the person to be vaccinated** | **No** | **Yes** |
|---|---|---|
| Are you sick today? | | |
| Do you have allergy to eggs, any component of a vaccine other than COVID-19 or an injectable medications or any other allergies? If yes, explain: | | |
| Have you ever had a serious reaction to the influenza vaccine in the past? Had wheezing or asthma in the past? | | |
| Have you had Guillain-Barre syndrome; epilepsy or other nervous system problems? If yes, explain: | | |
| Have you received any vaccinations in the past 4 weeks? | | |
| Females: Are you pregnant? | | |
| **--- Additional Questions for COVID Vaccine ---** | | |
| Have you received a dose of a COVID vaccine? If yes, which vaccine? | | |
| Have you received monoclinal 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? Ex: Cancer, HIV, organ transplant, immunosuppressive rugs or therapies, high-dose corticosteroids or others | | |
| Have you had blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome? | | |
| Do you have dermal fillers (cosmetic medical device implants)? | | |
| Have you ever had a severe allergic reaction (anaphylaxis) to anything? List: | | |

TO BE COMPLETED BY THE VACCINE ADMINISTRATOR

## Flu

| Vaccine Type | CPT | Manufacturer Lot # / Exp Date | Site | Dose Route | Nurse Initials | VIS Date |
|---|---|---|---|---|---|---|
| Fluzone / Fluad HD 65+ | 90662 / 90694 | | __RD __LD | 0.5ml IM | | 08/06/2021 |
| Flublok High Dose 50+ | 90682 | | __RD __LD | 0.5ml IM | | 08/06/2021 |
| MVD Fluzone 6 mo & older | 90688 | | __RD __LD | 0.5ml IM | | 08/06/2021 |
| Fluzone/Flulaval/Fluarix PF 2 yrs & older | 90686 | | __RD __LD | 0.5ml IM | | 08/06/2021 |
| Flucelvax PF 2 yrs & older | 90674 | | __RD __LD | 0.5ml IM | | 08/06/2021 |
| FLUMIST PF LAIIV 2 yrs - 49 yrs | 90672 | | Nostril | 0.2ml | | 08/06/2021 |
| TDAP | 90715 | | __RD __LD | 0.5ml IM | | 08/06/2021 |
| Pneumonia PPSV23 | 90732 | | __RD __LD | 0.5ml IM | | 10/30/2019 |
| Zoster (0,2-6mo) 50 yrs & older | 90750 | | __RD __LD | 0.5ml IM | | 02/04/2022 |
| Other | | | __RD __LD | | | |

## Covid-19 Last dose:_____ Date:_____ ☐ 1st Dose ☐ 2nd Dose ☐ 3rd Dose ☐ Booster

| Vaccine Type | CPT | Manufacturer Lot # / Exp Date | Site | Dose Route | Nurse Initials | EUA |
|---|---|---|---|---|---|---|
| Pfizer | | | __RD/ VR __LD/ VL | | | |
| Moderna | | | __RD/ VR __LD/ VL | | | |
| Novavax | | | __RD __LD | | | |
| Janssen | | | __RD __LD | | | |

## Seventh Grade

| Vaccine Type | CPT | Manufacturer Lot # / Exp Date | Site | Dose Route | Nurse Initials | VIS Date |
|---|---|---|---|---|---|---|
| Tdap 7 yrs & older | 90715 | | __RD __LD | 0.5ml IM | | 08/06/2021 |
| Meningococcal (MCV4) | 90619 | | __RD __LD | 0.5ml IM | | 08/06/2021 |
| HPV9 (9-14 yrs/0,6mo) (15-26 yrs/0,2,6mo) | 90651 | | __RD __LD | 0.5ml IM | | 08/06/2021 |
| Other | | | __RD __LD | | | |

## Kindergarten

| Vaccine Type | CPT | Manufacturer Lot # / Exp Date | Site | Dose Route | Nurse Initials | VIS Date |
|---|---|---|---|---|---|---|
| Kinrix / Quadracel Age 4-6 yrs (5 dose tap & 4 Polio) | 90696 | | __RD __LD | 0.5ml IM | | 10/15/2021 |
| MMR / Varicella (Proquad) (12-18 mo & 4-6 yrs) or (0 -1 mo) | 90710 | | __RA/ VL __LA/ VL | 0.5ml SQ | | 10/15/2021 |
| HEP A Ped (0, 6 mo) Age 1 - 18 yrs | 90633 | | __RD __LD | 0.5ml IM | | 10/15/2021 |

PAYMENT SECTION (For Office Use Only)

| Cash $ | Credit $ | Check #/$ | VFC Eligible ☐ | By |
|---|---|---|---|---|

Updated (07/14/2022)