Davis County Health Department

VACCINE ADMINISTRATION RECORD

ADULT ENGLISH

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

Last Name	**First Name**	**Middle**	**Date of Birth (mm/dd/yy)**	**Patient Age**
Language	**Race** ☐ White ☐ Asian ☐ Black ☐ American Indian ☐ Alaskan Native ☐ Pacific Islander	**Ethnicity** ☐ Hispanic ☐ Non Hispanic		**Gender** ☐ Male ☐ Female
Address:		**City**	**State**	**Zip Code**
Cell Phone #	**Alternate Phone #**	**E-mail**		
Primary Health Insurance:	**Policy #**	**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 (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.

PRINT NAME: _____ **SIGNATURE:** _____ **DATE:** _____

Relationship: ☐ Self ☐ Parent or Guardian **Staff Initials:** _____

Screening Questionnaire - Please complete for the person to be vaccinated

The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.	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 medications that affect your immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid 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?	☐	☐
Do you have dermal fillers (cosmetic medical device implants)?	☐	☐
Have you ever had a severe allergic reaction (anaphylaxis) to anything? List:	☐	☐

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TO BE COMPLETED BY THE VACCINE ADMINISTRATOR

	Immunizations	CPT code	Vaccinations			Vaccine Administration Date:			Manufacturer, Lote & Expiration Date	Current VIS provided
			Current	Recommended	D/D	Site	Route	Dose		Initials
Routine	**Covid-19:**_____ ☐ 1 ☐ 2 ☐ 3 ☐ Booster		☐	☐		☐**RD** ☐**LD**	IM			
Routine	**Hepatitis A Adult (Havrix)** 19 yrs & older (0, 6 mo)	90632	☐	☐		☐**RD** ☐**LD**	IM	1.0 ml		
Routine	**Hepatitis B Adult (Engerix)** 20 yrs & older (0, 1, 6 mo)	90746	☐	☐		☐**RD** ☐**LD**	IM	0.5 ml		
Routine	**Hepatitis B (Heplisav-B)** 18 yrs & older (0, 1 mo)	90739	☐	☐		☐**RD** ☐**LD**	IM	0.5 ml		
Routine	**Hep A-Hep B (Twinrix)** 18 yrs & older (0, 1, 6 mo) (1,7, 21 d, 12 mo)	90636	☐	☐		☐**RD** ☐**LD**	IM	1.0 ml		
Routine	**HIB (Pedvax)**	90647	☐	☐		☐**RD** ☐**LD**	IM	0.5 ml		
Routine	**HPV9 (Gardasil)** (15-26 yrs: 0, 2, 6 mo) (27-45 yrs: 0, 2, 6 mo)	90651	☐	☐		☐**RD** ☐**LD**	IM	0.5 ml		
Routine	**Influenza** 6 mo & older		☐	☐						
Routine	**MCV4 (Menquadfi)** 12 yrs, 16 yrs & older	90619	☐	☐		☐**RD** ☐**LD**	IM	0.5 ml		
Routine	**Men B (Bexero)** 16 yrs-23 yrs (0, 1 mo)	90620	☐	☐		☐**RD** ☐**LD**	IM	0.5 ml		
Routine	**Men B (Trumenba)** 16 yrs-23 yrs (0, 6 mo)	90621	☐	☐		☐**RD** ☐**LD**	IM	0.5 ml		
Routine	**MMR** (0, 1 mo)	90707	☐	☐		☐**RA** ☐**LA**	SQ	0.5 ml		
Routine	**PCV20/ PPSV23/ PCV13** 90670	90677 90732	☐	☐		☐**RD** ☐**LD**	IM	0.5 ml		
Routine	**Polio (IPV)**	90713	☐	☐		☐**RD** ☐**LD**	IM	0.5 ml		
Routine	**TDaP (Adacel)** 7 yrs & older	90715	☐	☐		☐**RD** ☐**LD**	IM	0.5 ml		
Routine	**Varicella (Varivax)** (0, 1 mo)	90716	☐	☐		☐**RA** ☐**LA**	SQ	0.5 ml		
Routine	**Zoster (Shingrix)** 50 yrs & older (0, 2-6 mo)	90750	☐	☐		☐**RD** ☐**LD**	IM	0.5 ml		
Travel	**Cholera (Vaxchora)** 18 yrs & older	90625	☐	☐		ORAL	PO	100 ml		
Travel	**Japanese Encephalitis** 2 yrs & older (0, 28 d) 18 yrs & older (0, 7 d)	90738	☐	☐		☐**RD** ☐**LD**	IM	0.5 ml		
Travel	**Rabies** (Pre-Ex 0, 7 d) (Post exp see MD RX)	90675	☐	☐		☐**RD** ☐**LD**	IM	0.5 ml		
Travel	**Typhoid Oral (Vivotif)** 6 yrs & older (0, 2, 4, 6 d)	90690	☐	☐		ORAL	PO	4 Tabs		
Travel	**Typhoid Inj (Typhim)** 2 yrs & older	90691	☐	☐		☐**RD** ☐**LD**	IM	0.5 ml		
Travel	**Yellow Fever (YF-Vax)** 9 mo & older	90717	☐	☐		☐**RA** ☐**LA**	SQ	0.5 ml		
Travel	**Other**		☐	☐						

☐ Traveler: Country(s)_____ R/R: _____

PAYMENT SECTION (FOR OFFICE USE ONLY)

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