

Information collected on this form will be used to document authorization for receipt of vaccine(s). Information may be shared through the North Dakota Immunization Information System (NDIIS) with other entities in accordance with North Dakota Century Code 23-01-05.3.

Patient's name: (Last, First, Middle)				Race: (Check box) <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown			
Hispanic or Latino: (Circle) Yes No		Date of birth:	Age:	Sex (Circle): Male Female			
Address: (Street or P.O. box)							
City:		State:	Zip code:	County:		Birth state or birth country (if not U.S.):	
Primary telephone number:			Work telephone number:		Email:		
Mother's name (if patient is 18 years or younger): Last, First, Middle				Mother's maiden name (if patient is 18 years or younger):			

A copy of the appropriate CDC Vaccine or Immunization Information Statement(s) or Immunization Information Statement has been provided. I have read, or have had explained, the information about the disease(s) and the vaccine(s) listed below. There was an opportunity to ask questions and all questions were answered satisfactorily. I believe that I understand the benefits and risks of the vaccine(s) cited and ask that the vaccine(s) listed below be given to me or to the person named above (for whom I am authorized to make this request).

Signature – Person to receive vaccine or person authorized to sign on the patient's behalf:	Date:
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VFC eligibility status: (Check all that apply) American Indian Medicaid-eligible No insurance
 Underinsured (vaccines not covered by health insurance) Not eligible (vaccines covered by health insurance) Other state eligible

✓	Vaccine(s) to be given	VIS/IIS date ¹	Manufacturer ²	Lot number	PB/PV ³	Lot Expiration	Admin site ⁴	Route ⁵	Person admin ⁶
	COVID19 <5 6m-11 5-11 12+		PFZ MOD NOV					IM	
	DTaP		GSK SP					IM	
	DTaP-HepB-IPV (Pediarix®)		GSK					IM	
	DTaP-IPV/Hib (Pentacel®)		SP					IM	
	DTaP-IPV-Hib-HepB (Vaxelis™)		MSD					IM	
	DTaP-IPV		GSK SP					IM	
	Hepatitis A		GSK MSD					IM	
	Hepatitis B		DYN GSK MSD					IM	
	Hep A-Hep B (Twinrix®)		GSK					IM	
	Hib (<i>H. influenzae</i> type B)		GSK MSD SP					IM	
	HPV-9		MSD					IM	
	Influenza							IM/IN	
	IPV		SP					IM/SQ	
	MMR		MSD GSK					IM/SQ	
	MMRV		MSD					IM/SQ	
	Meningococcal Group B		GSK PFZ					IM	
	MCV4		GSK SP					IM	
	PCV 15 20 21		PFZ MSD					IM	
	PPSV23		MSD					IM/SQ	
	Rotavirus		GSK MSD					PO	
	RSV (Adult)		GSK MOD PFZ					IM	
	RSV mAb ⁷		MSD SP					IM	
	Td		GRF SP					IM	
	Tdap		GSK SP					IM	
	Varicella		MSD					IM/SQ	
	Zoster		GSK					IM	

Signature of person administering vaccines	Date of vaccine administration
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1. **VIS/IIS date:** Document the publication date of the appropriate vaccine information statement (VIS) or immunization information statement (IIS) when applicable. If VIS or IIS is given on a date other than the date of immunization, also document the date it was given to patient or individual responsible for the patient.
2. **Manufacturer:** AZ = AstraZeneca, DYN = Dynavax, GSK = GlaxoSmithKline, GRF = Grifols, MSD = Merck & Co., MOD = Moderna, NV = Novartis, NOV = Novavax, PFZ = Pfizer, SP = Sanofi Pasteur, SEQ = Seqirus
3. **Indicate if public-supplied or privately purchased:** PB = Public-supplied, PV = Privately purchased
4. **Site Vaccine Given:** LA = Left Arm, RA = Right Arm, LT = Left Thigh, RT = Right Thigh
5. **Route:** ID = Intradermal, IM = Intramuscular, IN = Intranasal, PO = Oral, SQ = Subcutaneous
6. **Signature or initials of person administering vaccine:** Can be used if more than one person is administering vaccines
7. **RSV mAb:** This is a monoclonal antibody product that is a passive immunization. This not a vaccine. Administration of RSV mAb should be recorded in an equivalent manner.