NORTH Dakota | Health & Human Services
Be Legendary.

VACCINE ADMINISTRATION RECORD

Provider ID:

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)**
			☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown
Hispanic or Latino: (Circle) Yes No	**Date of birth:**	**Age:**	**Gender (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 Information Statement(s) or FDA Emergency Use Authorization Fact Sheet(s) 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:**

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/EUA date[1]	Manufacturer[2]	Lot number	S/P[3]	Lot Expiration	Admin site[4]	Route[5]	Person admin[6]
	COVID19 (monovalent bivalent) <5 <6 5-11 6-11 12+		PFZ MOD JSN 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 VBI					IM	
	Hep A-Hep B (Twinrix®)		GSK					IM	
	Hib (*H. influenzae* type B)		GSK MSD SP					IM	
	HPV-9		MSD					IM	
	Influenza							IM/IN	
	IPV		SP					IM/SQ	
	MMR		MSD GSK					SQ	
	MMRV		MSD					SQ	
	Meningococcal Group B		GSK PFZ					IM	
	MCV4		GSK SP					IM	
	PCV 13 15 20		PFZ MSD					IM	
	PPSV23		MSD					IM/SQ	
	Rotavirus		GSK MSD					PO	
	Td		GRF SP					IM	
	Tdap		GSK SP					IM	
	Varicella		MSD					SQ	
	Zoster		GSK					IM/SQ	

Signature of person administering vaccines	**Date of vaccine administration**

1. **VIS/EUA date:** Document the publication date of the appropriate vaccine information statement (VIS) or emergency use authorization (EUA) fact sheet, when applicable. If VIS or EUA fact sheet is given on a date other than the date of vaccination, 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, JSN = Janssen, MSD = Merck & Co., MOD = Moderna, NV = Novartis, NOV = Novavax, PFZ = Pfizer, SP = Sanofi Pasteur, SEQ = Seqirus, VBI = VBI Vaccines, Inc
3. **Indicate if state-supplied (i.e., public) or privately purchased:** S = State-supplied, P = 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