NORTH Dakota
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COVID-19 VACCINE ADMINISTRATION RECORD

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF DISEASE CONTROL
SFN 61915 (12-2020)

NDIIS 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 ☐ Other ☐ Unknown	
Hispanic or Latino: ☐ Yes ☐ No	Date of Birth:	Age:		
Gender: ☐ Male ☐ Female	Primary Telephone No.:	Telephone Number Type: ☐ Home ☐ Mobile ☐ Work		
Address (Street or P.O. Box):		City:	State:	ZIP Code:
County:	Birth State or Birth Country (If not U.S.):	Name of Person Financially Responsible:		
Mother's Name: Last, First, Middle (If younger than 18 years)		Mother's Maiden Name: (If younger than 18 years)		

Non-Medicare Insurance Information			**Medicare Insurance Information**	
ND Medicaid Number:			Medicare Claim Number:	
Insurance Plan Name:			Effective Date Part A:	Effective Date Part B:
ID Number:	Plan or Group Number:		**Other Medicare Insurance (Medica or Humana)**	
Policy Holder Name:	Date of Birth:	Relationship:	Plan Name:	ID Number:
Policy Holder Address (if different):			Address:	

☐ Check here if person receiving the vaccine **does not** have insurance, Medicare or Medicaid

A copy of the appropriate Emergency Use Authorization Face Sheet has been provided. I have read, or have had explained, the information about the disease and the vaccine 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 cited and ask that the vaccine listed below be given to me or to the person named above (for whom I am authorized to make this request).	
I consent to receive the vaccine provided. (Signature of patient or parent/guardian).	**Date:**

Priority Groups for COVID Vaccine (Select all that apply):

- ☐ Healthcare personnel (i.e. paid and unpaid personnel working in healthcare settings, local public health personnel, long term care staff)
- ☐ Long-term care resident
- ☐ Essential worker (i.e. emergency medical services, education, fire, law enforcement, utility, energy, etc.)
- ☐ Adult aged 65 years or older
- ☐ Underlying health condition (i.e. COPD, heart disease, diabetes, chronic kidney disease, obesity)
- ☐ Live-in other congregate setting
- ☐ Unknown

Talk to your healthcare provider **prior to vaccination** if you answer *yes* to any of the following:

Question	Yes	No	Unknown
Have you had a severe allergic reaction (e.g., anaphylaxis) to a previous vaccine or other injectable therapy?	If yes, please specify:		
Have you had a severe allergic reaction (e.g., anaphylaxis) to food, medicine, or other?	If yes, please specify:		
Have you received any vaccines in the past fourteen days?			
Have you tested positive for COVID-19?	If yes, when?		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment within the past 90 days?			
Do you currently have a fever?			
Do you have a bleeding disorder or are on a blood thinner?			
Are you pregnant, planning to become pregnant or breastfeeding?			

DO NOT WRITE BELOW THIS LINE

✓	COVID Vaccine Presentation	EUA Fact Sheet Date	Route[1]	Manufacturer[2]	Lot Number	Admin Site[3]	Person Admin[4]
	COVID-19 (Pfizer)		IM	PFR			
	COVID-19 (Moderna)		IM	MOD			

Signature and Title of Person Administering Vaccine:	Date Administered:

1. **Route:** IM = Intramuscular
2. **Manufacturer:** MOD = Moderna, PFR = Pfizer
3. **Site Vaccine Given:** LA = Left Arm, RA = Right Arm, LT = Left Thigh, RT = Right Thigh
4. **Signature or initials of person administering vaccine:** Can be used if more than one person is administering vaccines