Davis County Health Department
VACCINE ADMINISTRATION RECORD

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

Clinic Location:______________________ Date:________________

Last Name	**First Name**	**Middle**	**Date of Birth (mm/dd/yy)**	**Patient Age**
Language	**Race** ☐ White ☐ Asian ☐ Black ☐ Alaskan Native ☐ American Indian ☐ Pacific Islander ☐ Other ______	**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:	**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	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)?		

PAYMENT SECTION (FOR OFFICE USE ONLY)

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

Davis County Health Department
VACCINE ADMINISTRATION RECORD

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

TO BE COMPLETED BY THE VACCINE ADMINISTRATOR

VACCINE TYPE	CPT code	Manufacturer, Lote & Expiration Date	Vaccine Administration Date:			Current VIS provided
			Site	Route	Dose	Initials
FLUZONE HIGH DOSE 65+	90662		☐RD ☐LD	IM	0.7 ml	
FLUBLOK HIGH DOSE 18+	90682		☐RD ☐LD	IM	0.5 ml	
FLUZONE, FLULAVAL 6 MON+	90686		☐RD ☐LD	IM	0.5 ml	
FLUARIX (AHB ONLY) 19+	QUAD4		☐RD ☐LD	IM	0.5 ml	
FLUCELVAX 6 MON+	90674		☐RD ☐LD	IM	0.5 ml	
FLUMIST 2-49 yrs	90672		Nostril	Intranasal	0.2 ml	
TDAP	90715		☐RD ☐LD	IM	0.5 ml	
PNEUMONIA PPSV23	90332		☐RD ☐LD	IM	0.5 ml	
PNEUMONIA PCV20	90677		☐RD ☐LD	IM	0.5 ml	
ZOSTER (SHINGLES) (0,2-6 mon) 50yrs+	90750		☐RD ☐LD	IM	0.5 ml	
RSV ABRYSVO	90678		☐RD ☐LD	IM	0.5 ml	
RSV AREXVY	90679		☐RD ☐LD	IM	0.5 ml	
OTHER			☐RD ☐LD			
OTHER			☐RD ☐LD			

VACCINE TYPE	CPT code	Manufacturer, Lote & Expiration Date	Vaccine Administration Date:			Current VIS provided
			Site	Route	Dose	Initials
PFIZER			☐RD ☐LD	IM		
MODERNA			☐RD ☐LD	IM		
NOVAVAX			☐RD ☐LD	IM	0.5 ml	

VACCINE TYPE	CPT code	Manufacturer, Lote & Expiration Date	Vaccine Administration Date:			Current VIS provided
			Site	Route	Dose	Initials
MCV4 (MENQUADFI)	90619		☐RD ☐LD	IM	0.5 ml	
HPV9 (GARDASIL)	90651		☐RD ☐LD	IM	0.5 ml	
DTAP, POLIO (KINRIX, QUADRACEL)	90696		☐RD ☐LD	IM	0.5 ml	
MMR, VARICELLA (PROQUAD)	90710		☐RA/VL ☐LA/VL	SQ	0.5 ml	

PAYMENT SECTION (FOR OFFICE USE ONLY)

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