Davis COUNTY HEALTH DEPARTMENT

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

Davis County Health Department
VACCINE ADMINISTRATION RECORD
CHILD ENGLISH

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
Is your child sick today? Explain:		
Does your child have allergies to medications, food, vaccine components, or latex? Explain:		
Has your child had a serious reaction after receiving a vaccination? Explain:		
If your child is a baby, have you ever been told he/she has had intussusception?		
Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy? Child <5 years of age with recurrent wheezing?		
Has your child had cancer, leukemia, AIDS, or any other immune system problem? or in the past 3 months, has the child taken medications that affect the immune system such as prednisone, steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?		
Has your child, a sibling, or a parent had a seizure; has your child had brain or other nervous system problems?		
During the past year, has your child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?		
Has your child received any vaccinations in the past 4 weeks? Explain:		
Is your child/teen pregnant or is there a chance she could become pregnant during the next month?		
--- Additional Questions for COVID Vaccine ---	No	Yes
Has your child received a dose of a COVID vaccine? If yes, which vaccine?		
Has your child received monoclonal antibodies or convalescent plasma for COVID to prevent or treat COVID-19?		
Has your child tested positive for COVID in the past 10 days?		
Does your child have a health condition or is undergoing treatment that makes them moderately or severely immunocompromised? Ex: Cancer, HIV, organ transplant, immunosuppressive drugs or therapies, high-dose corticosteroids or others		
Has your child had blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome?		
Does your child have dermal fillers (cosmetic medical device implants)?		
Has your child ever had a severe allergic reaction (anaphylaxis) to anything? List:		

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VACCINE ADMINISTRATION RECORD

CHILD

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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/VL ☐LD/VL	IM			
	DTaP (Daptacel) 2, 4, 6, 15-18 mo, 4-6 yrs	90700	☐	☐		☐RD/VL ☐LD/VL	IM	0.5 ml		
	Hepatitis A Ped (Havrix) 12 mo-18 yrs (0, 6 mo)	90633	☐	☐		☐RD/VL ☐LD/VL	IM	0.5 ml		
	Hepatitis B Ped (Engerix) Birth-19 yrs (0, 1 mo, 6 mo)	90744	☐	☐		☐RD/VL ☐LD/VL	IM	0.5 ml		
	HIB (Pedvax) 2, 4, 6, 12-15 mo	90632	☐	☐		☐RD/VL ☐LD/VL	IM	0.5 ml 1.0 ml		
	HPV9 (Gardasil) (9-14 yrs: 0, 6 mo) (15-26 yrs: 0, 2, 6 mo)	90651	☐	☐		☐RD/VL ☐LD/VL	IM	0.5 ml		
	Influenza 6 mo & older		☐	☐						
	MCV4 (Menquadfi) 12 yrs, 16 yrs & older	90619	☐	☐		☐RD/VL ☐LD/VL	IM	0.5 ml		
	Men B (Bexero / Trumenba) 16-23 yrs (0, 1 mo) / (0, 6 mo)	90620 90621	☐	☐		☐RD/VL ☐LD/VL	IM	0.5 ml		
	MMR 12-18 mo & 4-6 yrs (0, 1 mo)	90707	☐	☐		☐RA/VL ☐LA/VL	SQ	0.5 ml		
	PCV13/PPSV23	90670 90732	☐	☐		☐RD/VL ☐LDVL	IM	0.5 ml		
	Polio (IPV)	90713	☐	☐		☐RD/VL ☐LD/VL	IM	0.5 ml		
	Rotavirus (Rotateq) 2, 4, 6-8 mo	90680	☐	☐		ORAL	PO	2.0 ml		
	TDaP (Adacel) 7 yrs & older	90715	☐	☐		☐RD/VL ☐LD/VL	IM	0.5 ml		
	DTaP-Polio (Kinrix/Quadracel) 4-6 yrs (5 doses DTaP & 4 Polio)	90696	☐	☐		☐RD/VL ☐LD/VL	IM	0.5 ml		
	DTaP-Polio-Hep B (Pediarix) 6 wks-6 yrs (2, 4, 6 mo) 1st 3 doses DTaP	90723	☐	☐		☐RD/VL ☐LD/VL	IM	0.5 ml		
	DTaP-HIB-Polio (Pentacel) 6 wks-4 yrs (2, 4, 6, 15-18 mo) 1st 4 doses DTaP	90698	☐	☐		☐RD/VL ☐LD/VL	IM	0.5 ml		
	MMR-Varicella (ProQuad) 12 mo-12 yrs (12-15 mo & 4-6 yrs)	90710	☐	☐		☐RD/VL ☐LD/VL	SQ	0.5 ml		
	DTaP-Polio-Hep B-HIB (Vaxelis) 6 wks-4 yrs (2, 4, 6 mo)	90697	☐	☐		☐RD/VL ☐LD/VL	IM	0.5 ml		
	Varicella (Varivax) 12-18 mo & 4-6 yrs	90716	☐	☐		☐RA/VL ☐LA/VL	SQ	0.5 ml		
Travel	**Japanese Encephalitis** 2 yrs & older (0, 28 d) 18 yrs & older (0, 7 d)	90738	☐	☐		☐RD/VL ☐LD/VL	IM	0.5 ml		
	Rabies (Pre-Ex 0, 7 d) (Post exp see MD RX)	90675	☐	☐		☐RD/VL ☐LD/VL	IM	0.5 ml		
	Typhoid Oral (Vivotif) 6 yrs & older (0, 2, 4, 6 d)	90690	☐	☐		ORAL	PO	4 Tabs		
	Typhoid Inj (Typhim) 2 yrs & older	90691	☐	☐		☐RD ☐LD	IM	0.5 ml		
	Yellow Fever (YF-Vax) 9 mo & older	90717	☐	☐		☐RA/VL ☐LA/VL	SQ	0.5 ml		
	Other		☐	☐						

☐ Traveler country(s)______________________ R/R: ______________________

PAYMENT SECTION (FOR OFFICE USE ONLY)

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