

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)	
Hispanic or Latino: (Circle) Yes No		Date of birth:	Age:	<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	
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:		E-mail address:	
Mother's name (if patient is 18 years or younger): Last, First, Middle			Mother's maiden name (if patient is 18 years or younger):		
<p>A copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Statement(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).</p>					
Signature – Person to receive vaccine or person authorized to sign on the patient's behalf:				Date:	

Eligibility status: (Check all that apply) THIS SECTION MUST BE COMPLETED

VFC-eligible (18 and younger only): <input type="checkbox"/> American Indian <input type="checkbox"/> Medicaid-eligible <input type="checkbox"/> No insurance <input type="checkbox"/> Underinsured (vaccines not covered by health insurance) <input type="checkbox"/> Unaccompanied minor without insurance information	Other state-eligible <input type="checkbox"/> Medicaid-eligible (ages 22 – 26) <input type="checkbox"/> No insurance <input type="checkbox"/> Underinsured (vaccines not covered by health insurance) <input type="checkbox"/> Insured adult who refuses to allow parents' insurance billed Not eligible for state-supplied vaccine <input type="checkbox"/> Medicaid-eligible (ages 19 – 21) <input type="checkbox"/> Insured
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✓	Vaccine(s) to be given	Route	VIS date ¹	Manufacturer ²	Lot number	S/P ³	Admin. site ⁴	Person admin. ⁵
	HPV	IM		GSK MSD				

Exemption or contraindication ⁷ :	Date of exemption or contraindication:
Signature and title of person administering vaccine:	Date vaccine administered:

1. **VIS date:** Document the publication date of the appropriate VIS. If VIS is given on a date other than the date of vaccination, also document the date VIS was given to patient or individual responsible for the patient.
 2. **Manufacturer:** GSK = GlaxoSmithKline, MSD = Merck & Co.
 3. **Indicate if state-supplied or privately purchased:** S = State-supplied, P = Privately purchased
 4. **Site Vaccine Given:** LA = Left Arm, RA = Right Arm
 5. **Signature or initials of person administering vaccine:** Can be used if more than one person is administering vaccines