North Carolina Immunization Registry

Mass Clinic Form

Name of Organization:_____ Chart Number: _____

YOU MUST COMPLETE ALL FIELDS BELOW.

Information collected on this form will be used to document authorization for receipt of vaccine(s).

Patient's Name (Last, First, Middle Initial)	Mother's Maiden Name (Last, First, Middle Initial)

Date of Birth (mm/dd/yyyy)	Gender	Ethnicity (Check One)
	☐ Male ☐ Female	☐ Hispanic ☐ Non-Hispanic

Race (Check all that apply)

☐ Asian ☐ American Indian or Alaskan Native ☐ White ☐ Unknown
☐ Black or African-American ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race

Name of Parent or Guardian Responsible for Patient (Last, First, Middle Initial)	Relationship to Patient

Address	P.O. Box

City	County	State	Zip Code

Email Address (if applicable)	Home Telephone Number	Work Telephone Number	Extension
	( )	( )	

PLEASE ANSWER ALL OF THE FOLLOWING:

1. Are you currently pregnant? ☐ YES ☐ NO
2. Do you have any acute/chronic medical conditions such as heart disease, diabetes, asthma, cancer or any condition that affects your immune system? ☐ YES ☐ NO
3. Have you gotten any other vaccines in the past 4 week? ☐ YES ☐ NO
4. Have you ever had a reaction to a previous dose of influenza vaccine? ☐ YES ☐ NO
5. Do you have an allergy to eggs? ☐ YES ☐ NO

I am authorized by the parent, guardian, or person standing in loco parentis of the above-named child to obtain needed immunizations for the child.

I/parental designee have received the "Vaccine Information Statements" (VIS) about the disease(s) and vaccine(s). I have had a chance to review the VIS(s) and to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request the vaccine(s) indicated below to be given to me or 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 Signed
X	

FOR OFFICE USE ONLY:

Eligibility: ☐ American Indian/Alaskan Native ☐ Medicaid ☐ Not Insured ☐ Underinsured ☐ NC Health Choice ☐ Insured

Vaccine	Trade Name	Lot #	VIS Pub. Date	Date VIS Presented	Body Route	Body Site*	mL.
Influenza					IM	RV LV RD LD	
FLU – Nasal					IN	BN RN LN	
PPSV					IM SC	RV LV RD LD	
Other							

* RV = Right Vastus Lateralis LV = Left Vastus Lateralis RD = Right Deltoid LD = Left Deltoid BN = Bilateral Nares RN = Right Naris LN = Left Naris

SIGNATURE AND TITLE – Person Administering Vaccine	Date Vaccine Administered