

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity (Check One) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Race (Check all that apply)			
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> White	<input type="checkbox"/> Unknown
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> 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. Is the person to be vaccinated sick today? YES NO
2. Does the person to be vaccinated have an allergy to a component of the vaccine? YES NO
3. Has the person to be vaccinated ever had a serious reaction to influenza in the past? YES NO
4. Has the person to be vaccinated ever had Guillain-Barré syndrome? YES NO
5. Are you currently pregnant? 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	
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