

# North Carolina Immunization Registry

Mass Clinic Form

Name of Organization: WAKE COUNTY HUMAN SERVICES

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. Are you currently pregnant?  YES  NO
2. Are you employed as a healthcare worker providing direct patient care?  YES  NO
3. 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
4. Do you live in a home with any infants under 6 months of age?  YES  NO
5. Have you ever had a reaction to a previous dose of influenza vaccine?  YES  NO
6. 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. I also hereby acknowledge that I have received a copy of the Wake County Notice of Privacy Practices.

SIGNATURE – Person to receive vaccine or person authorized to sign on the patient's behalf <b>X</b>	Date Signed
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**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.
H1N1					IM	RV LV RD LD	
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
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