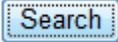


# NORTH DAKOTA IMMUNIZATION INFORMATION SYSTEM (NDIIS)

## PRINTING CERTIFICATE OF IMMUNIZATION

1. Search for a client's record by:
  - a. entering search criteria in the basic or expanded search fields
    - can use keyboard and *tab* through each field
  - b. click  or hit *Enter* on the keyboard to start search



### Client Lookup

Prov: 04921 User: (testmw-4921)

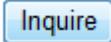
[Help](#)

Basic Search  Patient Account #:

Birth:   Social Security #:

First:  Last:

Last Name	First Name	MI	Birth Date	Alias	Address	City	State
TESTER	ADDISON	H	03/24/2010		95 LIND LANE	HARWOOD	ND

2. To view a record from the list of possible matches:
  - a. highlight the correct person from the list and click  or
  - b. double-click the name from the list

- The system will open the record on the **Demographics** tab
  - ❖ **Reminder:** update any information that is no longer correct

 **TESTER, ADDISON H** Prov: 04921 User: (testmw-4921)

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Demographics [Immunizations](#) [Comments](#) [Maintenance](#)

**Patient Information** Last Updated 08/01/2012

* Last Name: TESTER	* Address: 95 LIND LANE Apt:
* First Name: ADDISON	
* Middle Name: H	<input type="checkbox"/> Air Force Base
Suffix: <input type="text"/>	* City: HARWOOD
* Race: WHITE	* State: NORTH DAKOTA
* Ethnicity: NOT HISPANIC OR LATINO	* Zip: 58042
* Birth Date: 03/24/2010	County: CASS
<input type="checkbox"/> Is Multiple Birth (twins, triplets, etc)	* Birth State/Country: NORTH DAKOTA
SSN: <input type="text"/>	* Primary Phone: 701-219-4426
* Gender: FEMALE	Work Phone: <input type="text"/> Ext: <input type="text"/>
Alias: <input type="text"/>	Email Address: <input type="text"/>
Patient Acct #: <input type="text"/>	<input type="checkbox"/> Exclude client from reminder recall

**Mother Information** **Parent/Guardian Information**

*Last Name: TESTER	Last Name: TESTER
*First Name: LINDSEY	First Name: LINDSEY
Middle: <input type="text"/>	
Maiden Name: NOT TESTER	<input type="button" value="No Reactions/Comments"/>

Fields Appearing with an Asterisk (\*) Are Required.

- To access the certificate of immunization, click on the **Immunizations** tab under the client's name

 **TESTER, ADDISON H**

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5. From the client's immunization screen, click

[Print Certificate](#)

Demographics **Immunizations** Comments Maintenance

Dose Date	Provider	Lot	Reaction	VFC	Vaccine	Historical	Valid
03/24/2010	1093 - SANFORD MEDICAL CENTER	HBV/PreservativeFree	NONE	NOT ELIGIBLE	HEPB (Preservative Free)	Yes	Yes
05/24/2010	4895 - SANFORD SW PEDIATRICS	DTAP-HIB-IPV	NONE	NOT ELIGIBLE	DTaP-Hib-IPV (Pentacel)	Yes	Yes Yes Y
05/24/2010	4895 - SANFORD SW PEDIATRICS	HBV/PreservativeFree	NONE	NOT ELIGIBLE	HEPB (Preservative Free)	Yes	Yes
05/24/2010	4895 - SANFORD SW PEDIATRICS	PCV13	NONE	NOT ELIGIBLE	PCV13 (PNEUMOCOCCAL)	Yes	Yes
05/24/2010	4895 - SANFORD SW PEDIATRICS	ROTAVIRUS (3 DOSE)	NONE	NOT ELIGIBLE	ROTAVIRUS (3 dose)	Yes	Yes
07/27/2010	4895 - SANFORD SW PEDIATRICS	DTAP-HIB-IPV	NONE	NOT ELIGIBLE	DTaP-Hib-IPV (Pentacel)	Yes	Yes Yes Y

[Vaccination Exemption](#) [Forecast](#) [VAERS](#) [Print Certificate](#) [Add](#) [Change](#) [Delete](#)

6. The certificate will open as a PDF document and is a complete record of all vaccinations (both valid and invalid doses) and vaccine exemptions recorded for the client in the NDIIS. The record contains the following information:

- a. the North Dakota state seal
- b. patient's name and birthdate
- c. vaccine name, date and if the dose validity
  - combination vaccines will show up in the section for each of the individual vaccine components
  - if a client received a dose or doses of HPV or Hepatitis B vaccine without parental consent, the dose will be visible in the NDIIS but will not print on the immunization certificate
- d. the certificate must be signed by a "Physician, Nurse, Clinic, Provider, Pharmacist, Local/State Health or Representative" in order to be considered valid

a



# North Dakota Department of Health Certificate of Immunization

This is an official document of immunization for the person listed below. This record can be given to early childhood facilities and school administrators. This record may not contain all doses and may need additional documentation to prove vaccinations given in other states or by other providers.

b

**TEST USERONE**

**Birth Date: 10/31/2008**

Vaccine	Date	Valid	Vaccine	Date	Valid
<b>INFLUENZA</b>			<b>PNEUMOCOCCAL</b>		
INFL (Inactivated W/P)	05/01/2009	YES	PCV7 (Pneumococcal)	12/31/2008	YES
INFL (Inactivated W/P)	06/03/2009	YES	PCV7 (Pneumococcal)	02/27/2009	YES
INFL (Inactivated W/P)	09/16/2009	YES	PCV7 (Pneumococcal)	05/01/2009	YES
INFL (Live virus)	11/23/2010	YES	PCV7 (Pneumococcal)	11/02/2009	YES
INFL (Live virus)	10/18/2011	YES	PCV13 (PNEUMOCOCCAL)	05/03/2010	YES
<b>DTP/DT/DTaP</b>			<b>HIB</b>		
DTaP-Hib-IPV (Pentacel)	12/31/2008	YES	DTaP-Hib-IPV (Pentacel)	12/31/2008	YES
DTaP-Hib-IPV (Pentacel)	02/27/2009	YES	DTaP-Hib-IPV (Pentacel)	02/27/2009	YES
DTaP-Hib-IPV (Pentacel)	05/01/2009	YES	DTaP-Hib-IPV (Pentacel)	05/01/2009	YES
DTaP-Hib-IPV (Pentacel)	11/02/2009	YES	DTaP-Hib-IPV (Pentacel)	11/02/2009	YES
<b>OPV/IPV</b>			<b>HEPATITIS B</b>		
DTaP-Hib-IPV (Pentacel)	12/31/2008	YES	HEP B (Preservative Free)	11/01/2008	YES
DTaP-Hib-IPV (Pentacel)	02/27/2009	YES	HBVP	12/31/2008	YES
DTaP-Hib-IPV (Pentacel)	05/01/2009	YES	HEP B (Preservative Free)	05/01/2009	YES
DTaP-Hib-IPV (Pentacel)	11/02/2009	YES			
<b>ROTA VIRUS</b>			<b>HAV</b>		
ROTA VIRUS (3 dose)	12/31/2008	YES	HAV (2 doses)	11/02/2009	YES
ROTA VIRUS (3 dose)	02/27/2009	YES	HAV (2 doses)	05/03/2010	YES
ROTA VIRUS (3 dose)	05/01/2009	YES			
<b>MMR</b>			<b>VARICELLA</b>		
MMR	11/02/2009	YES	CHICKENPOX	11/02/2009	YES

c

d

Fill out one below.

To the best of my knowledge, this person has received the immunizations required for age on the above dates.

\_\_\_\_\_  
(Physician, Nurse, Clinic, Provider, Pharmacist, Local/State Health or Representative) Date \_\_\_\_\_

My child has not met the minimum requirements for his/her age. I agree to resume immunizations within 30 days from the date I was notified (today's date noted below) that my child's immunizations are incomplete and to submit a signed Certificate of Immunization.

\_\_\_\_\_  
(Parent/Guardian) Date \_\_\_\_\_

Medical Exemption: The physical condition of the above named person is such that immunization would endanger life or health, or is medically contraindicated due to other medical conditions.

\_\_\_\_\_  
(Physician) Date \_\_\_\_\_

Religious/Philosophical/Moral Belief Exemption: Parent or guardian of the above named person adheres to a belief opposed to immunizations.

(Please check one.)     Religious     Philosophical     Moral

\_\_\_\_\_  
(Parent/Guardian) Date \_\_\_\_\_